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RULES OF GOVERNMENTAL AGENCIES

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INTRODUCTION

The Illinois Register is the official state document for publishing public notice of rulemaking activity initiated by State governmental agencies. The table of contents is arranged categorically by rulemaking activity and alphabetically by agency within each category.

Rulemaking activity consists of proposed or adopted new rules; amendments to or repealers of existing rules; and rules promulgated by emergency or peremptory action. Executive Orders and Proclamations issued by the Governor; notices of public information required by State Statute; and activities (meeting agendas; Statements of Objection or Recommendation, etc.) of the Joint Committee on Administrative Rules (JCAR), a legislative oversight committee which monitors the rulemaking activities of State Agencies; is also published in the Register.

The Register is a weekly update of the Illinois Administrative Code (a compilation of the rules adopted by State agencies). The most recent edition of the Code, along with the Register, comprise the most current accounting of State agencies' rulemakings.

The Illinois Register is the property of the State of Illinois, granted by the authority of the Illinois Administrative Procedure Act [5 ILCS 100/1-1, et seq.].

2007 REGISTER SCHEDULE VOLUME #31

Issue #	Rules Due Date	Date of Issue
1	December 26, 2006	January 5, 2007
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49	November 26, 2007	December 7, 2007
50	December 3, 2007	December 14, 2007
51	December 10, 2007	December 21, 2007
52	December 17, 2007	December 28, 2007

ILLINOIS BOARD OF EXAMINERS

NOTICE OF PROPOSED AMENDMENT

1) Heading of the Part: Certificate of Certified Public Accountant

2) Code Citation: 23 Ill. Adm. Code 1400

3) Section Number: 1400.90 Proposed Action: Amended

4) Statutory Authority: Authorized by Section 3 of the Illinois Public Accounting Act [225 ILCS 450/3]

5) A Complete Description of the Subjects and Issues Involved: A change is being made to allow first-time candidates to qualify to take the CPA exam while registered in their final term of classes. There is no diminution of academic requirements to qualify for the CPA examination. Candidates will still be required to meet all current educational requirements as stated in the Illinois Public Accounting Act and the Rules Governing the Certificate of Certified Public Accounting. No exam scores will be released without receipt of final official documentation proving completion of all critical courses and/or degree requirements. Because there is no testing during one month of each quarter, the lack of provisional approval forces candidates to defer testing a minimum of three to six months after coursework is completed. The delay is negatively impacting the number of persons able to complete the exam and be certified as CPAs.

6) Published studies or reports, and sources of underlying data, used to compose this rulemaking: Statistical data on the number of Illinois CPA candidates taking the uniform CPA exam and when, are kept in the Board office and available to the public. University faculty addressed the Board of Directors in 2005 and again in 2007 after the provisional policy was eliminated, outlining the negative impact of that action. Minutes of those meetings are available at the Board office. Many candidates also contacted the Board office indicating that lack of provisional approval negatively impacted their ability to take the CPA exam when their accounting knowledge was most relevant and up to date.

7) Will this rulemaking replace any emergency rulemaking currently in effect? Yes

8) Does this rulemaking contain an automatic repeal date? No

9) Does this rulemaking contain incorporations by reference? No

10) Are there any other proposed rulemakings pending on this Part? No

ILLINOIS BOARD OF EXAMINERS

NOTICE OF PROPOSED AMENDMENT

11) Statement of Statewide Policy Objective: This rulemaking does not create or expand a State mandate.

12) Time, Place, and Manner in which interested persons may comment on this proposed rulemaking: Comments on this proposed rulemaking may be submitted in writing for a period of 45 days following publication of this Notice. Comments should be submitted to:

Joanne Vician
Executive Director
Illinois Board of Examiners
100 Trade Centre Drive
Suite 403
Champaign IL 61820

217/531-0929

13) Initial Regulatory Flexibility Analysis:

A) Types of small businesses, small municipalities and not for profit corporations affected: None

B) Reporting, bookkeeping or other procedures required for compliance: None

C) Types of Professional skills necessary for compliance: The minimum of a bachelor's degree, plus additional semester hours to total 150 semester hours, including a concentration in accounting and business, are required to qualify to take the uniform CPA exam. In addition, core competencies, knowledge and skills are needed to pass the professional CPA exam and to become certified.

14) Regulatory Agenda on which this rulemaking was summarized: This rulemaking was not included on either of the 2 most recent regulatory agendas because: no regulatory agenda have been filed.

The full text of the Proposed Amendment is identical to the text of the Emergency Amendment that appears in this issue of the *Illinois Register* on page 11373.

ILLINOIS EMERGENCY MANAGEMENT AGENCY

NOTICE OF PROPOSED AMENDMENTS

1) Heading of the Part: Use of X-Rays in the Healing Arts Including Medical, Dental, Podiatry, and Veterinary Medicine

2) Code Citation: 32 Ill. Adm. Code 360

3)

Section Numbers:	Proposed Action:
360.20	Amendment
360.30	Amendment
360.40	Amendment
360.50	Amendment
360.75	Amendment
360.110	Amendment
360.120	Amendment
360.APPENDIX A	Amendment

4) Statutory Authority: Implementing and authorized by the Radiation Protection Act of 1990 [420 ILCS 40]

5) A Complete Description of the Subjects and Issues Involved: Changing all references to "Department" or the "Illinois Department of Nuclear Safety" to "Agency" or "Illinois Emergency Management Agency" pursuant to Executive Order #12, effective July 1, 2003. The Agency is proposing these amendments to: (1) define the term Radiologist Assistant; (2) clarify that human exposure to x-rays is prohibited unless authorized by a practitioner of the healing arts, a physician assistant, or an advanced practice nurse; (3) provide for operation of fluoroscopic x-ray equipment by a Radiologist Assistant under the supervision of a licensed practitioner certified by the American Board of Radiology or the American Osteopathic Board of Radiology; (4) require registrants using linear accelerators to institute a quality management program to require a physician's written directive for patient treatments, and to implement procedures to ensure that patient treatments are delivered as prescribed.

6) Any published studies or reports, along with the sources of underlying data, that were used when composing this rulemaking: None

7) Will this rulemaking replace any emergency rulemaking currently in effect? No

8) Does this rulemaking contain an automatic repeal date? No

9) Does this rulemaking contain incorporations by reference? No

ILLINOIS EMERGENCY MANAGEMENT AGENCY

NOTICE OF PROPOSED AMENDMENTS

10) Are there any other proposed rulemakings pending on this Part? No

11) Statement of Statewide Policy Objectives: The requirements imposed by the proposed rulemaking are not expected to require local governments to establish, expand, or modify their activities in such a way as to necessitate additional expenditures from local revenues.

12) Time, Place and Manner in which interested persons may comment on this proposed Rulemaking: Comments on this proposed rulemaking may be submitted in writing for a period of 45 days following publication of this Notice. The Agency will consider fully all written comments on this proposed rulemaking submitted during the 45 day comment period. Comments should be submitted to:

Kevin T. McClain
Chief Legal Counsel
Illinois Emergency Management Agency
1035 Outer Park Drive
Springfield, Illinois 62704

217/524-1003 (voice)
217/782-6133 (TDD)

13) Initial Regulatory Flexibility Analysis:

A) Types of small businesses, small municipalities or not for profit corporations affected: The Agency believes that this rulemaking will have no direct impact on any small businesses, small municipalities or not for profit corporations.

B) Reporting, bookkeeping or other procedures required for compliance: None

C) Types of professional skills necessary for compliance: None

14) Regulatory Agenda on which this rulemaking was summarized: January 2007

The full text of the Proposed Amendments begins on the next page:

ILLINOIS EMERGENCY MANAGEMENT AGENCY

NOTICE OF PROPOSED AMENDMENTS

TITLE 32: ENERGY
CHAPTER II: ILLINOIS EMERGENCY MANAGEMENT AGENCY
SUBCHAPTER b: RADIATION PROTECTION

PART 360
USE OF X-RAYS IN THE HEALING ARTS INCLUDING MEDICAL, DENTAL, PODIATRY, AND VETERINARY MEDICINE

Section
360.10 Scope
360.20 Definitions
360.30 General Requirements and Administrative Controls
360.40 General Equipment and Operation Requirements for Diagnostic X-Ray Systems
360.41 Additional Requirements for Use of Diagnostic X-Ray Systems in the Healing Arts of Medicine, Podiatry and Chiropractic
360.50 Fluoroscopic Systems
360.60 Radiographic Systems Other Than Fluoroscopic, Dental, Veterinary or Computed Tomography Systems
360.70 Mobile/Portable Radiographic Systems Other Than Systems Used Solely for Mammography (Repealed)
360.71 Additional Requirements for Facilities Performing Mammography (Repealed)
360.75 Computed Tomography (CT) Systems
360.80 Photofluorographic Systems (Repealed)
360.90 Dental Radiographic Systems
360.100 Veterinary Radiographic Systems
360.110 Therapy Systems Operating Below 1 MeV
360.120 Therapy Systems Operating at 1 MeV or Greater
360.APPENDIX A Medical Radiographic Entrance Exposure Measurement Protocol
360.APPENDIX B Mammography Dose Measurement Protocol (Repealed)
360.APPENDIX C Mammography Phantom Image Evaluation (Repealed)
360.APPENDIX D Computed Tomography Dose Measurement Protocol
360.APPENDIX E Minimum Quality Control Program for Medical Accelerators
360.ILLUSTRATION A Thimble and Pancake Chamber-Radiation Measuring Devices (Repealed)
360.ILLUSTRATION B Mammography Dose Evaluation Graph (Repealed)
360.TABLE A Mammography Dose Evaluation Table (Repealed)
360.TABLE B Half-Value Layer as a Function of Tube Potential
360.TABLE C Entrance Exposure Limits Per Intraoral Bitewing Film (Repealed)

AUTHORITY: Implementing and authorized by the Radiation Protection Act of 1990 [420

ILCS 40].

SOURCE: Filed April 20, 1974 by the Department of Public Health; old rules repealed, new rules adopted at 4 Ill. Reg. 25, p. 157, effective July 1, 1980; transferred to the Department of Nuclear Safety by P.A. 81-1516, effective December 3, 1980; codified at 7 Ill. Reg. 16406; amended at 10 Ill. Reg. 13271, effective July 28, 1986; amended at 13 Ill. Reg. 803, effective April 1, 1989; amended at 15 Ill. Reg. 6180, effective April 16, 1991; amended at 17 Ill. Reg. 17972, effective October 15, 1993; amended at 18 Ill. Reg. 11524, effective July 11, 1994; emergency amendment adopted at 19 Ill. Reg. 273, effective December 30, 1994, for a maximum of 150 days; emergency expired May 30, 1995; amended at 19 Ill. Reg. 8284, effective June 12, 1995; amended at 22 Ill. Reg. 5904, effective March 13, 1998; amended at 23 Ill. Reg. 14516, effective January 1, 2000; recodified to the Illinois Emergency Management Agency by Executive Order #12, effective July 1, 2003; amended at 31 Ill. Reg. _____, effective _____.

Section 360.20 Definitions

As used in this Part, the following definitions apply:

"Accelerator" (also "particle accelerator") means any therapeutic machine capable of producing a useful beam of x-rays or charged particles with energies of 1 MeV or greater. Accelerators include cyclotrons, betatrons and linear accelerators.

"Accelerator facility" means the location at which one or more particle accelerators are installed and are operated under the same administrative control.

"Agency" means the Illinois Emergency Management Agency.

"Aluminum equivalent" means the thickness of type 1100 aluminum alloy affording the same attenuation, under specified conditions, as the material in question. The nominal chemical composition of type 1100 aluminum alloy is 99.00 percent minimum aluminum, 0.12 percent copper.

"Applicator" means a structure which determines the extent of the treatment field at a given distance from the source of the beam.

"Attenuation block" means a block or stack, having dimensions 20 centimeters by 20 centimeters by 3.8 centimeters, of aluminum equivalent. Copper may be substituted for aluminum if an appropriate thickness is used for the kVp selected,

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as indicated below:

kVp	Millimeters of Copper Equivalent to 3.8 centimeters of aluminum
99 or less	2.0
100 to 125	2.5
greater than 125	3.0

"Automatic exposure control" means a device which automatically controls one or more technique factors in order to obtain at a preselected location(s) a required quantity of radiation (see "Phototimer").

"Barrier" (see "Protective barrier").

"Beam" means a flow of electromagnetic or particulate radiation which passes through the opening in the beam limiting device and which is used for diagnosis or treatment.

"Beam axis" (see "Central axis of the beam").

"Beam-limiting device" means a device which provides a means to restrict the dimensions of the x-ray field (see "Collimator", "Diaphragm" and "Shutter").

"Beam monitoring system" means a system of devices that will monitor the useful beam during irradiation and will terminate irradiation when a preselected number of monitor units has been accumulated.

"Beam scattering filter" means a filter placed in an electron beam in order to scatter the beam and provide a more uniform distribution of electrons in the beam.

"Central axis of the beam" means the line passing through the source of the beam and the center of the plane formed by the edge of the first beam-limiting device.

"Charged particle beam" (see "Beam").

"Coefficient of variation" means the ratio of the standard deviation to the mean value of a population of observations.

"Collimator" means a device or mechanism by which the x-ray beam is restricted

in size (see "Beam-limiting device").

"Computed tomography" or "(CT)" means the production of a tomogram by the acquisition and computer processing of x-ray transmission data.

"Computed tomography dose index" or "(CTDI)" means the integral of the dose profile along a line perpendicular to the tomographic plane divided by the product of the nominal tomographic section thickness and the number of tomograms produced in a single scan.

"Contact therapy system" means an x-ray system used for therapy which is designed for very short treatment distances (5 centimeters or less), usually employing peak tube potentials in the range of 20 to 50 kVp.

"Control panel" means that part or parts of the x-ray system upon which are mounted the switches, knobs, pushbuttons and other hardware necessary for setting the technique factors prior to initiating an x-ray exposure.

"CT gantry" means the tube housing assemblies, beam-limiting devices, detectors and the supporting structures and frames which hold these components.

"Dead-man switch" means a switch constructed so that a circuit-closing contact can be maintained only by continuous pressure on the switch by the operator.

"Diagnostic imaging specialist" means a person who possesses the knowledge, training and experience to apply the principles of radiological physics to diagnostic x-ray applications. The diagnostic imaging specialist shall be approved and registered by the Agency~~Department~~ pursuant to 32 Ill. Adm. Code 410.

"Diagnostic source assembly" means an x-ray tube housing assembly, designed for use in diagnostic x-ray applications, with a beam-limiting device attached.

"Diaphragm" means a device or mechanism by which the x-ray beam is restricted in size (see "Beam-limiting device").

"Direct supervision" means an individual is in the physical presence of a licensed practitioner who assists, evaluates and approves of the individual's performance of the various tasks involved in the application of ionizing radiation.

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"Field flattening filter" means a filter used to provide dose uniformity over the area of a useful beam of x-rays at a specified depth.

"Filter" means material placed in the useful beam to absorb, preferentially, radiations based on energy level or to modify the spatial distribution of the beam.

"Gantry" means that part of the system supporting and allowing possible movements of the radiation head.

"General purpose x-ray system" means any radiographic x-ray system which, by design, is not limited to radiographic examination of specific anatomical regions.

"Gonad shield" means a protective device for the testes or ovaries which provides a minimum of 0.5 millimeter lead equivalent protection.

"Half-value layer" or "(HVL)" means the thickness of a specified material that attenuates the beam of radiation to an extent such that the exposure rate is reduced to one-half of its original value.

AGENCY NOTE: The contribution of all scattered radiation, other than any that might be present initially in the beam concerned, should be minimized.

"Healing arts screening" means the examination of human beings using x-ray machines for the detection or evaluation of potential diseases when such examinations are not specifically ordered by a licensed practitioner of the healing arts legally authorized to prescribe such x-ray examinations for the purpose of diagnosis or treatment. However, healing arts screening does not include mammography on self-referred patients.

"Image intensifier" means a device, installed in a housing, which converts an x-ray pattern into a corresponding light image, usually by electronic means.

"Image receptor" means any device, such as a fluorescent screen or radiographic film, which transforms incident x-ray photons either into a visible image or into another form which can be made into a visible image by further transformations.

"Interlock" means a device arranged or connected such that the occurrence of an event or condition is required before a second event or condition can occur or

continue to occur.

"Isocenter" means a fixed point in space located at the center of the smallest sphere through which the central axis of the useful beam passes at any beam orientation.

"Kilovolts peak" or "~~(~~kVp~~)~~" means the crest value, in kilovolts, of the electric potential applied to the x-ray tube between the cathode and anode of a pulsating electric potential generator.

"Lead equivalent" means the thickness of lead affording the same attenuation, under specified conditions, as the material in question.

"Leakage radiation" means all radiation emanating from the diagnostic source assembly except for:

The useful beam; and

The radiation produced when the exposure switch or timer is not activated.

"Leakage technique factors" means the technique factors used to measure leakage radiation from the diagnostic source assembly. They are defined as follows:

For capacitor energy storage equipment, the maximum-rated peak tube potential and the maximum-rated number of exposures in 1 hour for operation at the maximum-rated peak tube potential with the quantity of charge per exposure being 10 millicoulombs, i.e., 10 milliampere-seconds, or the minimum obtainable from the unit, whichever is larger.

For field emission equipment rated for pulsed operation, the maximum-rated peak tube potential and the maximum-rated number of x-ray pulses in 1 hour for operation at the maximum-rated peak tube potential.

For all other equipment, the maximum-rated peak tube potential and the maximum-rated continuous tube current for the maximum-rated peak tube potential.

"Light field" means that area of the intersection of the light beam from the beam-limiting device and any one of the sets of planes parallel to and including the

plane of the image receptor. The edge of the light field is defined as the locus of points at which the illumination is 25 percent of that at the center of the light field.

"Medical radiographer" means a person other than a licensed practitioner, accredited in accordance with the provisions of 32 Ill. Adm. Code 401, or an individual exempt from the provisions of 32 Ill. Adm. Code 401, who performs medical radiation procedures and applies x-radiation, to any part of the human body, for diagnostic purposes while under the supervision of a licensed practitioner.

"Mobile equipment" (see "X-ray equipment").

"Monitor unit" means a unit response from the beam monitoring system from which the absorbed dose can be calculated.

"Moving beam therapy" means radiation therapy in which there is displacement of the useful beam relative to the patient. Moving beam therapy includes arc therapy, skip therapy and rotational beam therapy.

"Multiple scan average dose" or "~~(~~MSAD~~)~~" means the average dose at the center of a series of scans, specified at the center of the axis of rotation of a computed tomography system.

"Operator" means an individual who applies ionizing radiation for diagnostic or therapeutic purposes.

"Phototimer" means a method for controlling radiation exposures to image receptors by the amount of radiation which reaches a radiation monitoring devices~~device(s)~~. The radiation monitoring devices~~device(s)~~ is part of an electronic circuit which controls the duration of time the tube is activated (see "Automatic exposure control").

"Portable equipment" (see "X-ray equipment").

"Position indicating device" means a device on intraoral dental x-ray equipment used to indicate the beam position and to establish a definite source-skin distance.

"Primary protective barrier" (see "Protective barrier").

"Protective apron" means an apron of radiation absorbing materials, at least 0.25 millimeter lead equivalent, used to reduce exposure from leakage and scatter radiation.

"Protective barrier" means a barrier of radiation absorbing materials ~~material(s)~~ used to reduce radiation dose. The types of protective barriers are as follows:

"Primary protective barrier" means the material, excluding filters, placed in the useful beam to reduce the radiation dose.

"Secondary protective barrier" means a barrier sufficient to attenuate the leakage and scatter radiation to the required degree.

"Protective glove" means a glove made of radiation absorbing materials, at least 0.25 millimeter lead equivalent, used to reduce dose from leakage and scatter radiation.

"Radiation beam" (see "Beam").

"Radiation therapy simulation system" means a radiographic/ fluoroscopic x-ray system used exclusively for localizing the volume to be exposed during radiation therapy and confirming the position and size of the therapeutic irradiation field.

"Radiologist assistant" means a person, other than a licensed practitioner, who, as a medical radiographer with advanced-level training and certification, performs a variety of activities under the supervision of a radiologist certified by the American Board of Radiology or the American Osteopathic Board of Radiology, in the areas of patient care, patient management, clinical imaging and interventional procedures. The radiologist assistant may not interpret images, make diagnoses or prescribe medications or therapies.

"Reference plane" means a plane that ~~which~~ is displaced from and parallel to the tomographic plane.

"Scan" means the complete process of collecting x-ray transmission data for the production of a tomogram. Data can be collected simultaneously during a single scan for the production of one or more tomograms.

ILLINOIS EMERGENCY MANAGEMENT AGENCY

NOTICE OF PROPOSED AMENDMENTS

"Scan increment" means the amount of relative displacement of the patient support device with respect to the CT x-ray system between successive scans measured along the direction of such displacement.

"Scatter radiation" means radiation that, during passage through matter, has been deviated in direction.

"Secondary protective barrier" (see "Protective barrier").

"Shadow tray" means a device attached to the radiation head to support auxiliary beam-limiting material.

"Shutter" means an adjustable beam-limiting or attenuating device, usually made of lead, fixed to an x-ray tube housing to intercept or collimate the useful beam (see "Beam-limiting device").

"SID" means source-image receptor distance (see "Source-image receptor distance").

"Source" means the focal spot of the x-ray tube.

"Source-image receptor distance" means the distance from the source to the center of the input surface of the image receptor.

"Source to skin distance" or "~~(~~SSD~~)~~" means the distance measured along the central ray from the center of the front surface of the x-ray focal spot to the surface of the irradiated object.

"Special purpose x-ray system" means any radiographic x-ray system which, by design, is limited to radiographic examination of a specific anatomical region, or to the extremities collectively.

"Spot film" means a radiograph which is made during a fluoroscopic examination to permanently record conditions which exist during that fluoroscopic procedure.

"Stationary beam therapy" means radiation therapy in which there is no displacement of the useful beam relative to the patient during irradiation.

"Stationary equipment" (see "X-ray equipment").

"Supervision" means responsibility for and control of quality, radiation safety and protection, and technical aspects of the application of ionizing radiation to human beings for diagnostic and/or therapeutic purposes.

"Technique factors" means the electrical potential (kilovolts), current (milliamperes), exposure time parameters (seconds or pulses) or a combination thereof, selectable at the control panel of an x-ray system (see "Control panel").

"Therapeutic radiological physicist" means an individual who has the knowledge, training and experience to measure ionizing radiation, evaluate safety techniques, advise regarding radiation protection needs and apply the principles of radiological physics to clinical radiation therapy. The therapeutic radiological physicist shall be approved and registered by the Agency~~Department~~ pursuant to 32 Ill. Adm. Code 410.

"Tomogram" means the depiction of the x-ray attenuation properties of a section through the body.

"Tomographic plane" means that geometric plane which is identified as corresponding to the output tomogram.

"Tomographic section" means the volume of an object whose x-ray attenuation properties are imaged in a tomogram.

"Useful beam" (see "Beam").

"X-ray equipment" means an x-ray system, sub-system or component thereof. Types of x-ray equipment are as follows:

"Mobile x-ray equipment" means x-ray equipment mounted on a permanent base with wheels and/or casters for moving while completely assembled. Mobile x-ray equipment includes x-ray equipment permanently mounted in vehicles.

"Portable x-ray equipment" means x-ray equipment designed to be hand-carried.

"Stationary x-ray equipment" means x-ray equipment that~~which~~ is

installed in a fixed location.

"X-ray field" means, for diagnostic purposes, that area of the intersection of the useful beam and any one of the set of planes parallel to and including the plane of the image receptor. The edge of the x-ray field is defined as the locus of points at which the exposure is 25 percent of that at the center of the x-ray field.

"X-ray system" means an assemblage of components for the controlled production of x-rays. It includes minimally an x-ray high-voltage generator, an x-ray control panel, an x-ray tube housing assembly, a beam-limiting device and the necessary supporting structures. Additional components that~~which~~ function with the system are considered integral parts of the system. X-ray systems include diagnostic systems, therapeutic systems and accelerator systems.

(Source: Amended at 31 Ill. Reg. _____, effective _____)

Section 360.30 General Requirements and Administrative Controls

The requirements in this Section apply to all uses of x-rays in veterinary medicine and to all uses of x-rays in the healing arts including the use of x-rays for both diagnostic and therapeutic purposes. Additional requirements for all diagnostic x-ray systems are in Section 360.40 of this Part and specific equipment application classes are contained in Sections 360.41 through 360.100 of this Part. For therapeutic x-ray systems also see Sections 360.110 and 360.120 of this Part.

a) Registrant. The registrant shall:

1) Direct the operation of the x-ray systems~~system(s)~~;

2) Register with the Agency~~Department~~, in accordance with the provisions of 32 Ill. Adm. Code 320, all x-ray equipment which is used at the facility and all portable or mobile x-ray equipment used by the registrant;

3) Verify that each individual required to be accredited by 32 Ill. Adm. Code 401 to apply x-rays for either diagnostic or therapeutic purposes is properly accredited with the Agency~~Department~~ prior to allowing the individual to apply medical radiation procedures on human beings;

4) Permit operation of the x-ray systems~~system(s)~~ only by individuals who are licensed in accordance with State law (see Section 360.10(a) of this

Part), or who are accredited by the Agency~~Department~~ pursuant to 32 Ill. Adm. Code 401 or who are exempt from such requirements in accordance with the provisions of 32 Ill. Adm. Code 401.

b) Shielding. Each installation shall be provided with such primary barriers and/or secondary barriers as are necessary to assure compliance with the provisions of 32 Ill. Adm. Code 340.210, 340.270, 340.280 and 340.310.

c) An x-ray system which does not meet the provisions of this Part shall not be operated for diagnostic or therapeutic purposes.

d) If an x-ray system is identified as not being in compliance with the provisions of this Part and if that system is accessible for use, it shall be rendered inoperable (i.e., dismantle the x-ray source from the source support assembly) if so ordered by the Director.

e) Prohibitions

1) Unauthorized Exposure. Individuals shall not be exposed to the useful beam except for healing arts purposes and only when such exposure has been authorized by a licensed practitioner of the healing arts, or by a physician assistant, or by an advanced practice nurse. This provision specifically prohibits deliberate exposure for the following purposes:

A) Exposure of individuals for training, demonstration or other non-healing arts purposes.

B) Exposure of individuals for the purpose of "healing arts screening" (see Section 360.20 of this Part).

2) Fluoroscopy shall not be used as a substitute for radiography or in lieu of proper anatomical positioning/centering procedures prior to radiographic studies.

3) Fluoroscopic equipment using phosphorescent screens shall not be used. Image intensification shall be utilized on all fluoroscopic equipment.

4) The use of direct exposure x-ray film (without intensifying screens) for routine diagnostic radiological imaging procedures, other than intraoral

dental radiography and therapeutic portal imaging, is prohibited.

AGENCY NOTE: Therapeutic portal imaging is a technique used in radiation therapy to verify correct alignment of therapy beams with the patient's anatomy.

5) The use of photofluorographic systems is prohibited.

AGENCY NOTE: Photofluorography is frequently called mass miniature radiography. In this technique the image of a fluorescent screen is recorded on film by means of a camera.

f) Individual Monitoring and Reporting Requirements. All persons who are associated with the operation of an x-ray system are subject to the radiation dose standards, requirements for the determination of the doses, requirements for individual monitoring and requirements for reporting of radiation doses which are contained in 32 Ill. Adm. Code 340.

g) The registrant shall comply with the requirements of the Agency's~~Department's~~ rules entitled, Notices, Instructions and Reports to Workers; Inspections, 32 Ill. Adm. Code 400.

h) Records and Associated Information. The registrant shall maintain at the facility, for a period of at least one inspection cycle (see 32 Ill. Adm. Code 320.10(c)), records showing the receipt, transfer, storage and disposal of all sources of radiation in accordance with the provisions of 32 Ill. Adm. Code 310 and 320.

i) Staff Qualifications. The registrant shall maintain at the facility, for review by the Agency~~Department~~, current certificates of accreditation (clear, legible copies are acceptable), issued by the Agency~~Department~~ in accordance with the provisions of 32 Ill. Adm. Code 401, for all individuals who are required to be so accredited.

j) Radiation Safety Procedures. The registrant shall provide to each individual who operates x-ray equipment at the facility written operating and safety procedures. These procedures shall include restrictions required for the safe operation of each radiation machine and shall include the topics listed in the radiation safety program of subsection (k) of this Section.

k) Radiation Safety Program. The registrant shall provide for initial and annual in-

service training in radiation safety for individuals (excluding licensed practitioners) that apply ionizing radiation at the facility, to ensure their awareness of the registrant's radiation safety practices and policies. The in-service training shall include the following topics:

1) Operating and emergency procedures for the radiation machines~~machine(s)~~;

2) Use of personnel and patient protective devices;

3) Procedures to minimize patient and occupational doses, including procedures for selecting personnel to support patients or film, as required by Section 360.40 of this Part;

4) Use of individual monitoring devices (if such devices are used at the facility);

5) Film processing procedures; and

6) Prohibited uses of x-ray machines, as described in subsection (e) of this Section.

l) Operator Training. Individuals who operate radiation machines shall be instructed in and able to demonstrate competence with the registrant's operating and safety procedures.

(Source: Amended at 31 Ill. Reg. _____, effective _____)

Section 360.40 General Equipment and Operation Requirements for Diagnostic X-Ray Systems

The requirements of this Section apply to all diagnostic x-ray systems. Additional requirements for specific equipment application classes are in Sections 360.41 through 360.100 of this Part.

a) Half-Value Layer

1) The half-value layer of the useful beam for a given x-ray tube potential shall not be less than the values shown in Section 360. Table B of this Part.

2) For capacitor energy storage equipment, compliance with the requirements of this subsection (a) shall be determined with the system fully charged and a setting of 10 mAs for each exposure.

b) Beam-On Indicators

1) The control panel shall include a device (usually a milliammeter or labeled indicator lamp) which will give positive indication of the production of x-rays whenever the x-ray tube is energized.

2) Where two or more radiographic tubes are controlled by one exposure switch, the tube or tubes which have been selected shall be clearly indicated prior to initiation of the exposure. This indication shall be both on the x-ray control panel and at or near the tube housing assembly which has been selected.

c) Mechanical Support of Tube Head. The tube housing assembly supports shall be adjusted such that the tube housing assembly will remain stable during an exposure unless tube housing movement is a designed function of the x-ray system. The tube housing assembly supports shall not be hand-held unless the manufacturer has specifically designed the system to be operated while hand-held.

d) Diagnostic Source Assembly Leakage Radiation Limits. The leakage radiation measured at a distance of 1 meter from the source shall not exceed 25.8 microC/kg (100mR) in 1 hour when the tube is operated at its leakage technique factors.

e) Radiation From Capacitor Energy Storage X-ray Equipment in Standby Status. Radiation emitted from the x-ray tube when the exposure switch or timer is not activated shall not exceed a rate of 0.516 microC/kg (2mR) per hour at 5 centimeters from any accessible surface of the diagnostic source assembly, with the beam-limiting device fully open.

f) Technique Indicators

1) The technique factors to be used during an exposure shall be indicated at the control panel before the exposure begins. If automatic exposure controls are used, the technique factors which are set prior to the exposure

shall be indicated at the control panel.

2) The requirement of subsection (f)(1) of this Section may be met by permanent markings on equipment having fixed technique factors. Indication of technique factors shall be visible from the operator's position except in the case of spot films.

3) The indicated technique factors of exposure time and kilovolts peak (kVp) shall correspond to the actual exposure factors within ten percent of the indicated values.

g) Reproducibility of Exposures

1) For any specific combination of selected technique factors utilized, the coefficient of variation of radiation exposures shall not exceed 0.05 for any specific combination of selected technique factors.

AGENCY NOTE: It will not be necessary to calculate the coefficient of variation if for the first four measurements the value of the average exposure (Eavg) is greater than or equal to ten times the maximum exposure (Emax) minus the minimum exposure (Emin). This requirement is mathematically represented by the following:

$$Eavg = 10 (Emax - Emin)$$

2) For systems using automatic exposure control (AEC) (i.e., systems employing photo-multiplier tubes, or ionization chambers to terminate the x-ray exposure), compliance measurements shall be performed with the system operating in the AEC mode. Attenuating material shall be placed in the beam to provide exposure times in the range of those used clinically.

AGENCY NOTE: The intent of this subsection (g) is to require testing of the system in a manner that is clinically relevant. Reproducibility of exposures should be measured at technique factors that are commonly used and are subject to variation. For AEC systems, commonly used settings in combination with an appropriate thickness of attenuating material should be used to provide exposure times in the clinical range.

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h) Patient or Film Support

1) When a patient or film must be provided with auxiliary support during a radiation exposure:

A) No person shall be used routinely to hold film or patients; and

B) Unless the procedure precludes their use, mechanical holding devices shall be used to restrain patients. For example, mechanical holding devices could not be used if the devices would preclude clear visualization of the tissue being examined.

2) When a patient or film must be held by an individual, written safety procedures, as required by Section 360.30(j) of this Part, shall indicate the criteria for selecting a holder and the procedure the holder shall follow.

AGENCY NOTE: The radiation dose received by radiation workers, patients and the general public can be reduced if mechanical patient and film support devices are used for radiographic and fluoroscopic procedures. In the event that an individual must be used in lieu of mechanical patient or film support devices to hold patients or films, every effort should be made to limit the individual's radiation dose. This can be accomplished by not assigning to a single individual the task of supporting patients and films during radiographic and fluoroscopic examinations. Rather, a number of individuals may be rotated through the assignment, thereby reducing the radiation dose to one individual.

i) Personnel Protection

1) Except for patients who cannot be moved out of the room, only the individuals required for the medical procedure or training shall be in the room during the radiographic/flouroscopic exposure.

2) Individuals who must be in the room with the patient being radiographed or fluoroscoped shall be protected by 0.25 millimeter lead equivalent apparel or device or shall be positioned at a distance such that the individual does not receive a radiation dose in excess of the limits specified in 32 Ill. Adm. Code 340.310.

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j) Technique Guides

1) In the vicinity of each radiographic x-ray system's control panel, a technique guide shall be provided which specifies for routine examinations performed with that system, the following information:

A) Patient's anatomical size versus technique factors to be utilized;

B) Type of screen-film combination utilized, if more than one; and

C) SID to be used.

2) For automatic exposure control (AEC) systems with selectable exposure detectors and density settings, the technique guide shall also specify the appropriate exposure detectors~~detector(s)~~ and density setting to be utilized for each radiographic examination listed.

3) For AEC systems, if operated in a non-automatic mode, the technique guide shall specify the requirements of subsections (j)(1)(A) through (C) of this Section to be followed.

AGENCY NOTE: The Agency~~Department~~ recognizes that alternate means may be available at the control panel to indicate technique factors for computerized imaging systems.

k) Patient Dose Criteria. Procedures and auxiliary equipment designed to minimize patient and occupational dose commensurate with needed diagnostic information shall be used.

AGENCY NOTE: It is the intent of this subsection (k) to provide for the optimum optical density, resolution and contrast on the film while minimizing patient dose. X-ray films, intensifying screens and other image recording devices should be as sensitive as is consistent with the requirements of the examination.

l) X-ray Film Processing Systems. The darkroom safe light illumination shall be adequate for the film speeds~~speed(s)~~ and the darkroom operating procedures used to prevent fogging of unprocessed film. The following additional requirements apply to film processing systems:

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1) Manual film processing systems shall be monitored by the registrant to assure:

A) The use of a dedicated darkroom timer with an adjustable preset function. The timer shall be used to adjust film processing time according to solution temperature.

B) The use of a dedicated darkroom thermometer. The thermometer shall be used to adjust the film processing time according to solution temperature.

C) The use of a film processing guide. The guide shall contain, at a minimum, information regarding times~~time(s)~~ and temperatures~~temperature(s)~~ (as recommended by the film manufacturer) used by the registrant to develop radiographs.

D) The frequency at which film processing chemicals are changed is appropriate for the conditions of use.

2) Automated film processing shall be monitored by the registrant to assure:

A) The temperature of film processing chemicals and the film transport speed is appropriate for the type of films~~film(s)~~ being utilized.

B) The film processing chemicals used and their replenishing rate (if applicable) are appropriate for the type of films~~film(s)~~ and quantity processed.

m) Gonadal Shielding. Except for cases in which it would interfere with the diagnostic procedure, gonadal shielding of not less than 0.5 millimeter of lead equivalent shall be used for patients (who have not passed the reproductive age) during those radiographic procedures in which the gonads are in the useful beam.

AGENCY NOTE: Protection of the embryo or fetus from radiation dose during radiological examination or treatment of a woman of childbearing age (potentially pregnant) should be given special consideration.

(Source: Amended at 31 Ill. Reg. _____, effective _____)

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Section 360.50 Fluoroscopic Systems

In addition to the provisions of Sections 360.10, 360.30, 360.40 and 360.41 of this Part, the requirements of this Section apply to x-ray equipment and associated facilities used for fluoroscopy.

a) Beam Limitation. The x-ray field shall be limited by stepless adjustable shutters. In addition:

1) The minimum field size at the greatest SID shall be no greater than 5 centimeters by 5 centimeters.

2) The mechanisms~~mechanism(s)~~ (manual/automatic mode selectors~~selector(s)~~) provided for activating and positioning the beam-limiting shutters shall function properly. This requirement applies to shutters used in fluoroscopic procedures or spot filming procedures or both fluoroscopic and spot filming procedures.

3) Neither the length nor the width of the x-ray field in the plane of the image receptor shall exceed that of the visible area of the image receptor by more than three percent of the SID. The sum of the excess length and the excess width shall be no greater than four percent of the SID. This requirement applies to field sizes for fluoroscopic procedures or spot filming procedures or both fluoroscopic and spot filming procedures.

4) For fluoroscopic equipment with only a manual mode of beam limitation, the x-ray field produced shall be limited to the area of the spot film cassette at 40.6 centimeters (16 inches) above the tabletop. Additionally, during fluoroscopy, the operator shall restrict the beam to the area of the input phosphor.

5) Spot film devices shall meet the following additional requirements:

A) Means shall be provided between the source and the patient for adjustment of the x-ray field size in the plane of the image receptor to the size which has been selected on the spot film selector. Such adjustment shall be accomplished automatically except when the x-ray field size in the plane of the image receptor is smaller than that

selected;

B) The center of the x-ray field in the plane of the image receptor shall be aligned with the center of the selected portion of the film to within two percent of the SID; and

C) If the angle between the plane of the image receptor and beam axis is variable, a device shall be provided to visually indicate when the axis of the x-ray beam is perpendicular to the plane of the image receptor.

6) The beam limitation requirements of this subsection shall not apply to fluoroscopic systems specifically designed for examination of extremities only and meeting the requirement of subsection (l) of this Section.

b) Fluoroscopic Timer. A manual reset, cumulative timing device shall be used which will either indicate elapsed on-time by an audible signal or turn off the system when the total exposure time exceeds a predetermined limit not exceeding 5 minutes in one or a series of exposures.

c) Primary Barrier/Interlock. These devices shall be provided and shall function so that:

1) The entire cross section of the useful beam is intercepted by the primary protective barrier of the fluoroscopic image assembly at any SID; and

2) The fluoroscopic tube is interlocked to prevent the unit from producing x-rays unless the primary barrier is in position to intercept the useful beam, as specified in subsection (1) of this Section, at all times.

d) Source-Skin Distance. The SSD shall not be less than:

1) 38 centimeters (15 inches) on all stationary fluoroscopes;

2) 20 centimeters (8 inches) on all mobile fluoroscopes; and

3) 9 centimeters (3.5 inches) for fluoroscopes specifically designed for examination of extremities only and meeting the requirements of subsection (l) of this Section.

e) Indication of Potential and Current. During fluoroscopy and recording of fluoroscopic images, the kVp and the mA shall be continuously indicated at the control panel and/or the operator's position.

f) Activation of the Fluoroscopic Tube. X-ray production in the fluoroscopic mode shall be controlled by a device which requires continuous pressure by the operator for the entire time of any exposure. When recording serial fluoroscopic images, the operator shall be able to terminate the x-ray exposures~~exposure(s)~~ at any time, but means may be provided to permit completion of any single exposure of the series in process.

g) Entrance Exposure Requirements

1) Maximum Exposure Rate. Fluoroscopic systems shall not be operable at any combination of tube potential and current which will result in an exposure rate in excess of 2.58 mC/kg (10 R) per minute at the point where the center of the useful beam enters the patient, except:

A) During recording of fluoroscopic images; or

B) When an optional high level control is activated (see subsection (g)(2)).

2) When a high level control is activated, the equipment shall not be operable at any combination of tube potential and current which will result in an exposure rate in excess of 5.15 mC/kg (20 R) per minute at the point where the center of the useful beam enters the patient. In addition, the following requirements apply to high level controls:

A) Separate means of activation of high level controls shall be required. The high level control shall only be operable when continuous manual activation is provided by the operator.

B) A continuous signal audible to the operator shall indicate that the high level control is being employed.

3) Compliance with the requirements of subsections (g)(1) and (2) of this Section shall be determined using technique factors that produce the

maximum exposure rate. For systems employing automatic exposure rate control, material having an equivalency of at least 3 millimeters of lead shall be placed in the primary beam between the image receptor and the radiation measuring device. The lead or equivalent material shall be positioned to ensure that the entire primary beam is blocked.

AGENCY NOTE: Many fluoroscopic systems do not yield their maximum exposure rate at the maximum tube potential or tube current. The exposure rate should be checked at various kVp and mA settings to establish the maximum exposure rate for the system.

4) Fluoroscopic systems shall not be operable at any combination of tube potential and current that will result in an exposure rate in excess of 1.29 mC/kg (5 R) per minute at the point where the center of the useful beam enters the patient, when measured under the following conditions:

A) Movable grids and compression devices shall be removed from the useful beam during the measurement.

B) For systems without automatic exposure rate control, the measurement shall be performed using technique factors clinically used for a standard adult patient thickness of 23 centimeters.

AGENCY NOTE: An attenuation block or other suitable material should be placed in the beam to protect the imaging system.

C) For systems with automatic exposure rate control, the measurement shall be performed with a 2.5 millimeter thick sheet of copper in the beam between the radiation measuring device and the image receptor.

AGENCY NOTE: Use of a 2.5 millimeter thick sheet of copper approximates the attenuation of a standard adult patient thickness of 23 centimeters, and assures consistency in the measurement of fluoroscopic exposure rate.

AGENCY NOTE: The Agency~~Department~~ recommends additional measurements be made of the entrance exposure rate for fluoroscopic systems capable of recording fluoroscopic images,

and the entrance exposure for spot film techniques for fluoroscopic systems with that modality. In either case, measurements should be made under the conditions specified in subsection (g)(4)(B) of this Section.

D) The requirements of subsection (g)(4) of this Section shall not apply to fluoroscopes specifically designed for examination of extremities only and meeting the requirements of subsection (1) of this Section.

5) Measurements performed pursuant to the requirements of subsections (g)(1) through (4) of this Section shall meet the following additional requirements:

A) If the source is below the table, the exposure rate shall be determined for the center of the useful beam 1 centimeter above the tabletop or cradle, with the input surface of the fluoroscopic imaging assembly positioned 30 centimeters (12 inches) above the tabletop.

B) If the source is above the table, the exposure rate shall be determined at 30 centimeters (12 inches) above the tabletop with the end of the beam-limiting device or spacer positioned as closely as possible to the point of measurement.

C) For a fixed SID C-arm type of fluoroscope, the exposure rate shall be determined 30 centimeters (12 inches) from the input surface of the fluoroscopic imaging assembly.

D) For a variable SID C-arm type of fluoroscope, the exposure rate shall be determined 30 centimeters (12 inches) from the input surface of the fluoroscopic imaging assembly with the end of the beam-limiting device or spacer positioned as close as possible to the point of measurement.

E) For a lateral type fluoroscope, the exposure rate shall be determined on the central axis of the primary beam at a point 15 centimeters (6 inches) from the centerline of the x-ray table and in the direction of the x-ray source with the end of the beam-limiting

device or spacer positioned as closely as possible to the point of measurement. If the tabletop is movable, it shall be positioned as closely as possible to the lateral x-ray source, with the end of the beam-limiting device or spacer no closer than 15 centimeters to the centerline of the x-ray table.

AGENCY NOTE: A lateral type fluoroscope is a fluoroscope that cannot be rotated so that the source or the fluoroscopic imaging assembly can be positioned below the fluoroscopic table or cradle.

F) For a fluoroscopic system specifically designed for examination of extremities only, the exposure rate shall be determined for the minimum source-skin distance.

6) The measurements required by this subsection (g) shall be performed when the system is inspected as specified in 32 Ill. Adm. Code 410 as well as after any maintenance of the system which might affect the exposure rate.

7) The results of the measurements required by subsections (g)(1), (2) and (4) of this Section shall be posted or available at the control panel. The measurement results shall be stated in millicoulombs per kilogram (roentgens) per minute or microcoulombs per kilogram (milliroentgens) per second and shall include the technique factors used in determining such results. The name of the individual performing the measurements and the date the measurements were performed shall be included in the results.

AGENCY NOTE: The resolution and efficiency of the fluoroscopic imaging system should be evaluated periodically, whenever deterioration in the imaging system is suspected and when the measured exposure rate exceeds the standards of this Section.

h) Barrier Transmitted Radiation Rate Limits

1) The exposure rate due to transmission through the primary protective barrier shall not exceed 0.516 microC/kg (2mR) per hour at 10 centimeters from any accessible surface of the fluoroscopic imaging assembly beyond the plane of the image receptor per 258 microC/kg (1R) per minute of

entrance exposure rate.

2) Measuring Compliance of Barrier Transmission

A) The exposure rate due to transmission through the primary protective barrier shall be determined by measurements averaged over an area of 100 square centimeters with no linear dimension greater than 20 centimeters.

B) If the source is below the tabletop, the exposure rate shall be determined with the input surface of the fluoroscopic imaging assembly positioned 30 centimeters above the tabletop.

C) If the source is above the tabletop and the SID is variable, the exposure rate shall be determined with the end of the beam-limiting device or spacer as close to the tabletop as it can be placed, provided that it shall not be closer than 30 centimeters.

D) Movable grids and compression devices shall be removed from the useful beam during the measurement.

E) An attenuation block shall be positioned in the useful beam 10 centimeters from the point of measurement of entrance exposure rate and between this point and the input surface of the fluoroscopic imaging assembly.

i) Staff and Ancillary Personnel Protection. The operator, assistants and observers allowed in the examining room shall be protected from scatter radiation by protective aprons of not less than 0.25 millimeter lead equivalent or whole body protective barriers or shall be positioned at a sufficient distance to ensure that the individual does not receive a radiation dose in excess of the limits specified in 32 Ill. Adm. Code 340.310.

j) Control of Scattered Radiation

1) For fluoroscopic systems utilizing an x-ray tube that is mounted below the table, the table shall be provided with shielding (bucky slot cover) equivalent to 0.25 millimeter lead equivalent to attenuate scattered radiation emanating from below the table.

2) A shield of at least 0.25 millimeter lead equivalent, such as overlapping protective drapes or hinged or sliding panels, shall be provided and used to intercept scatter radiation which would otherwise reach the operator and others near the machine. This shielding shall not be a substitute for the wearing of a protective apron (0.25 millimeter lead equivalent) for protection against scattered radiation.

3) Where sterile fields or special procedures prohibit the use of protective barriers or drapes, subsection (j)(2) of this Section shall not apply.

k) Additional Requirements for Stationary Fluoroscopic Systems Used for Cardiac Catheterization Procedures

1) Protective barriers shall be available for use by individuals whose presence is required in the room during activation of the x-ray tubes~~tube(s)~~. If a protective barrier includes or consists of a transparent viewing panel, the viewing panel shall afford protection of not less than 0.5 millimeter of lead equivalent.

2) Protective aprons of not less than 0.25 millimeter of lead equivalent shall be worn in the fluoroscopy room by all individuals (except the patient).

AGENCY NOTE: Because modern equipment allows great flexibility in the direction of the beam, individuals in the room should step back from the x-ray system and behind protective barriers during activation of the x-ray tubes~~tube(s)~~.

l) Additional Requirements for Fluoroscopic Systems Specifically Designed for Examination of Extremities Only

1) The radiation safety procedures required pursuant to Section 360.30(j) of this Part shall include the following:

A) A warning concerning the potential for, and the hazards of, increased patient radiation dose associated with x-ray systems employing short source-skin distances;

B) Procedures for obtaining imaging magnification with minimum

patient dose, including imaging systems or screen-film combinations;

C) Technique factors for specific examinations for which the system is designed;

D) Radiation exposure data, including skin entrance exposure for each set of technique factors used.

2) The x-ray system shall be clearly labeled as follows: "For Examination of Extremities Only."

3) Fluoroscopic systems specifically designed for examination of extremities only shall be used solely for examination of extremities.

m) Radiation Therapy Simulation Systems. Radiation therapy simulation systems shall be exempt from the requirements of subsections (a), (b), (c), (g) and (h) of this Section provided that:

1) Such systems are designed and used in such a manner that no individual other than the patient is in the x-ray room during periods of time when the system is producing x-rays; and

2) Such systems that do not meet the requirements of subsection (b) of this Section are provided with a means of indicating the cumulative time that an individual patient has been exposed to x-rays. Procedures shall require in such cases that the timer be reset between examinations.

n) Operator Restrictions. No person shall intentionally administer radiation to a human being with a fluoroscopic radiation machine unless such person is licensed to practice a treatment of human ailments under the Medical Practice Act of 1987, the Illinois Dental Practice Act or the Podiatric Medical Practice Act of 1987, except:

1) An accredited medical radiographer may operate a fluoroscope for static functions when diagnostic interpretation of the fluoroscopic image is not required by the radiographer and only under the supervision of a licensed practitioner; or

2) An accredited medical radiographer may operate a fluoroscope as directed by, and under the direct supervision of, a licensed practitioner who is physically present and participating in the procedure; or

3) An accredited medical radiographer or radiation therapist may operate a fluoroscope for radiation therapy simulation procedures under the supervision of a licensed practitioner; or.

4) An accredited radiologist assistant may operate a fluoroscope under the supervision of a licensed practitioner certified by the American Board of Radiology or the American Osteopathic Board of Radiology.

(Source: Amended at 31 Ill. Reg. _____, effective _____)

Section 360.75 Computed Tomography (CT) Systems

a) Requirements for Equipment

1) Termination of Exposure

A) In the event of equipment failure affecting data collection, means shall be provided to terminate the x-ray exposure automatically, either by de-energizing the x-ray source or by shuttering the x-ray beam, through the use of either a back-up timer or devices which monitor equipment function.

B) A visible signal shall indicate when the x-ray exposure has been terminated through the means required by subsection (a)(1)(A) of this Section.

C) The operator shall be able to terminate the x-ray exposure at any time during a scan, or series of scans, of greater than 0.5 second duration.

2) Tomographic Plane Indication and Alignment

A) Means shall be provided to permit visual determination of the location of a reference plane. This reference plane can be offset from the location of the tomographic planes.

B) If a device using a light source is used to satisfy subsection (a)(2)(A) of this Section, the light source shall provide illumination levels sufficient to permit visual determination of the location of the tomographic plane or reference plane under ambient light conditions of up to 500 lux (45 footcandles).

C) The total error in the indicated location of the tomographic plane or reference plane shall not exceed 5 millimeters.

D) The deviation of indicated scan increment versus actual increment shall not exceed plus or minus 1 millimeter with a typical patient mass resting on the patient support device. The patient support device shall be moved incrementally from a typical starting position to the maximum incremental distance or 30 centimeters, whichever is less, and then returned to the starting position. If the CT system has the capability of variable gantry angles, the compliance measurements shall be performed with the CT gantry positioned at zero degrees.

3) Beam-On and Shutter Status Indicators. The CT x-ray control panel and gantry shall provide visual indication whenever x-rays are produced and, if applicable, whether the shutter is open or closed.

4) Technique Indicators. The CT x-ray control panel shall provide visual indication of the technique factors, tomographic section thickness and scan increment prior to the initiation of a scan or a series of scans.

b) Facility Design Requirements

1) The control panel shall be located behind a protective barrier.

2) Communication. Provision shall be made for two-way aural communication between the patient and the operator at the control panel.

3) Viewing Systems. Windows, mirrors, closed-circuit television or an equivalent system shall be provided to permit continuous observation of the patient during irradiation and shall be located so that the operator can observe the patient from the control panel.

c) Radiation dose measurements shall be performed by a diagnostic imaging specialist on each CT x-ray system. Such measurements shall be specified in terms of the multiple scan average dose (MSAD), using a head phantom and the facility's technique factors most frequently used for a CT examination of the head and shall be performed:

1) At least annually by a diagnostic imaging specialist and after any change or replacement of components that~~which~~ could cause a change in the radiation output;

2) With a dosimetry system that has been calibrated within the preceding 12 months. The calibration of such system shall have no more than a three-step (tertiary) calibration, traceable to the National Institute of Standards and Technology; and

3) Using the computed tomography dose measurement protocol found in Section 360.Appendix D of this Part.

AGENCY NOTE: The Agency~~Department~~ recognizes that other phantoms and protocols are available to provide accurate dose measurements as specified in this Section. The Agency~~Department~~ will consider use of such phantoms and protocols as satisfying this Section if the intent of the regulation is met.

d) Quality assurance procedures shall be conducted on each CT system and shall meet the following requirements:

1) The quality assurance procedures shall be in writing and shall have been developed by a diagnostic imaging specialist. The~~Such~~ procedures shall include, but need not be limited to, the following:

A) Specifications of the tests that are to be performed, including instructions to be employed in the performance of those tests; and

B) Specifications of the frequency at which tests are to be performed, the acceptable tolerance for each parameter measured and actions to be taken if tolerances are exceeded.

2) Quality assurance procedures shall include acquisition of images using a

CT phantom which has the capability of providing an indication of the resolution capability of the system.

AGENCY NOTE: The CT phantom used for quality assurance procedures should have the capability of providing an indication of contrast scale, noise, nominal tomographic section thickness, resolution capability of the system for low and high contrast objects and relative densities (CT numbers) for water or other reference material.

e) Operating Procedures. Information shall be available at the control panel regarding the operation of the system. The~~Such~~ information shall include written quality assurance procedures, as required in subsection (d)(1) of this Section.

(Source: Amended at 31 Ill. Reg. _____, effective _____)

Section 360.110 Therapy Systems Operating Below 1 MeV

In addition to the provisions of Sections 360.10 through 360.30 of this Part, the requirements of this Section apply to x-ray therapy systems and associated facilities operating at energies less than 1 MeV.

a) Facility Design

1) A therapeutic radiological physicist shall be consulted in the design of an x-ray therapy installation.

2) Shielding requirements

A) Each x-ray therapy installation shall be provided with such primary and secondary barriers as are necessary to assure compliance with 32 Ill. Adm. Code 340.

B) For all x-ray therapy systems capable of operating above 150 kVp installed after October 15, 1993, facility design information shall be submitted to the Agency~~Department~~ for review prior to installation of the x-ray therapy system. Information submitted to the Agency~~Department~~ shall include, but need not be limited to, the following:

i) Name and address of the planned installation.

ii) Name, address and telephone number of the therapeutic radiological physicist who was consulted in the design of the installation.

iii) A scale drawing that includes the location of the therapy system, control panel and doors to the room.

iv) The structural composition and thickness of all walls, doors, partitions, floor and ceiling of the installation.

v) The occupancy of areas adjacent to the installation.

vi) Calculations that demonstrate the adequacy of the amount of shielding specified for each primary and secondary protective barrier.

vii) Projected weekly dose rates in areas adjacent to the installation.

3) Interlock. X-ray therapy systems operating at greater than 150 kVp shall have an interlock installed on each door of the therapy room. The interlock shall be wired into the electrical circuit in such a manner that when the door is opened, for any reason, the generation of x-rays will automatically be terminated and irradiation can be resumed only by manually resetting the controls on the control panel after the door is closed.

4) Doors. The doors to the therapy room shall be designed and installed to allow opening from the inside at all times and shall be capable of being opened manually.

5) Warning Lights. X-ray therapy systems operating above 150 kVp, and all therapy rooms to which access is possible through more than one entrance shall be provided with warning lights in a readily observable position near the outside of all access doors. The warning lights shall indicate when the useful beam is on.

6) Operator and control position

A) X-ray Therapy Systems Operating at 150 kVp and Below. The control panel and operator shall be located either outside the therapy room or behind a protective barrier within the room.

B) X-ray Therapy Systems Operating Above 150 kVp. The control panel and operator shall be located outside the therapy room.

7) Viewing System. Windows, mirrors, closed-circuit television or an equivalent system shall be provided to permit continuous visual observation of the patient during irradiation and shall be located so that the operator can observe the patient from the control panel.

AGENCY NOTE: When the primary viewing system is electronic, a back-up system should be available for use in the event of failure of the primary system in order to ensure compliance with the requirements of subsection (e)(5) of this Section.

8) Communication. The facility design shall permit two-way aural communications between the patient and the operator at the control panel.

9) Signs required by 32 Ill. Adm. Code 340.920 shall be posted in the facility.

b) Equipment Requirements

1) Leakage Radiation. When the tube is operated at its maximum rated continuous current for the maximum rated tube potential, the leakage radiation shall not exceed the value specified in the table below at the distance specified in the table for the classification of that x-ray system. Radiation measurements shall be averaged over an area up to, but not exceeding, 100 square centimeters.

X-Ray System	Leakage Limit	Measurement Location
Contact Therapy	25.8 microC/kg (0.1 R) per hour	5 centimeters from the tube housing

0 - 499 kVp	258 microC/kg (1 R) per hour	1 meter from the source
500 kVp - 999 kVp	0.1 percent of useful beam or 258 microC/kg (1 R) per hour, whichever is greater	1 meter from the source

2) Beam-Limiting Devices

A) Permanent fixed diaphragms or cones used for limiting the useful beam shall provide the same or a higher degree of protection as required for the tube housing assembly.

B) Removable beam-limiting devices shall, for the portion of the useful beam to be blocked by these devices, transmit not more than one percent of the useful beam at the maximum kilovoltage and maximum treatment filter. This requirement does not apply to auxiliary blocks or materials placed in the useful beam to shape the useful beam to the individual patient.

C) Adjustable beam-limiting devices installed after October 15, 1993 shall meet the requirements of subsection (b)(2)(B) of this Section.

D) Adjustable beam-limiting devices installed on or before October 15, 1993 shall, for the portion of the x-ray beam to be blocked by these devices, transmit not more than five percent of the useful beam at the maximum kilovoltage and maximum treatment filter.

3) Filter System. The filter system shall be designed so that:

A) The filters are securely positioned and will not become dislodged when the machine is positioned at any possible orientation;

B) The radiation dose at one meter from the filter insertion slot opening does not exceed 258 mC/kg (1 R) per hour when the machine is operated at its maximum current and maximum tube potential;

C) Each filter is labeled with its composition and thickness (for wedge filters, the wedge angle and maximum design field size shall appear on the wedge or wedge tray);

D) If the x-ray therapy system uses changeable filters, there is a filter indication system which permits recognition of any added filter in place and indicates from the control panel the presence of a particular filter or absence of any filter; and

E) For x-ray therapy systems installed after October15, 1993, an interlock prevents irradiation if the selected filter is not installed.

4) Tube/Aperture Alignment. The x-ray tube shall be mounted so that it cannot turn or slide with respect to the housing aperture.

5) Tube Housing Stability. The tube housing shall remain stable during treatment unless tube housing movement is a designed function of the system.

6) Source-Skin Distance (SSD) Indication

A) Means shall be provided to indicate the SSD.

B) The SSD shall be indicated in centimeters and/or inches and the measured SSD shall correspond to the indicated value to within 0.5 percent.

7) Timer. A timer, which has a display at the control panel, shall be provided and shall meet the following requirements:

A) The timer shall be activated with the production of radiation;

B) For systems equipped with a shutter mechanism to control irradiation, the timer shall be activated when the shutter is opened;

C) The timer shall terminate irradiation when a preselected time has elapsed;

D) The timer shall permit presetting and determination of exposure

times at least as short as 1 second; and

E) The timer shall not permit an exposure if the operator has not selected a time for the exposure.

AGENCY NOTE: The control panel should be equipped with a count-up timer to serve as a back-up to the control timer.

8) Control Panel Functions. The control panel, in addition to the displays required in other provisions of this Section, shall have:

A) An indication of whether x-rays are being produced;

B) A means for indicating x-ray tube potential and current; and

C) A means for terminating an exposure at any time.

9) Shutters. Equipment that is provided with shutters shall meet the following requirements:

A) The shutters shall have a lead equivalency not less than that of the tube housing assembly;

B) The shutter shall be controlled electrically by the operator at the control panel; and

C) An indication of shutter position shall appear at the control panel.

10) Multiple Tubes. Control panels capable of energizing more than one x-ray tube shall meet the following requirements:

A) It shall be possible to energize only one x-ray tube at any time;

B) There shall be an indication at the control panel identifying which x-ray tube is energized; and

C) There shall be an indication at the tube housing assembly when that tube is energized.

11) Low-Filtration X-Ray Tubes. Each x-ray therapy system equipped with a beryllium window shall be clearly labeled as such upon the tube housing assembly and at the control panel.

c) Radiation Protection Survey. A radiation protection survey shall be performed by a therapeutic radiological physicist on each x-ray therapy system. The registrant shall maintain at the facility a copy of the most recent radiation protection survey report for review by the Agency~~Department~~. Radiation protection surveys shall meet the following additional requirements:

1) X-ray therapy systems installed after October 15, 1993 shall have a radiation protection survey performed by a physicist before the therapy system is first used for irradiation of a patient.

2) For all x-ray therapy systems, a radiation protection survey shall be performed by a physicist after any change in the x-ray therapy system or facility that might produce a radiation hazard. The~~Such~~ survey shall be performed before the therapy system is used to treat patients.

3) Survey reports shall include, but need not be limited to, the following:

A) A diagram of the facility that~~which~~ details building structures and the position of the control panel, x-ray therapy system and associated equipment;

B) A description of the x-ray therapy system, including the manufacturer, model number and range of kilovolt potential;

C) A description of the instrumentation used to determine radiation measurements, including the date and source of the most recent calibration for each instrument used;

D) Conditions under which radiation measurements were taken; and

E) Survey data including:

i) Projected weekly dose equivalent in areas adjacent to the therapy room; and

ii) A description of workload, use and occupancy factors employed in determining the projected weekly dose equivalent.

4) The registrant shall retain a copy of the radiation protection survey report and a copy of the report shall be provided to the Agency~~Department~~ within 30 days after completion of the survey.

5) Any deficiencies detected during the radiation protection survey that would constitute or result in a violation of 32 Ill. Adm. Code 340 shall be corrected prior to using the machine for treatment of patients.

6) The facility shall be operated in compliance with any limitations indicated by the therapeutic radiological physicist as a result of the radiation protection survey required by the Agency~~Department~~.

d) Calibrations and Quality Assurance Checks.

1) Each x-ray therapy system installed after October 15, 1993 shall be calibrated by a therapeutic radiological physicist before the therapy system is first used for irradiation of a patient. The calibration of the x-ray therapy system shall include, but need not be limited to, determination of the following:

A) The radiation output, expressed as exposure rate in air or dose rate in tissue, as a function of distance, field size, x-ray tube potential and current, filters and treatment applicators used;

B) The half-value layer for each kilovoltage setting and filter combination used;

C) The degree of congruence between the radiation field and the field indicated by each beam-limiting device; and

D) An evaluation of the uniformity of the radiation field.

2) Quality assurance checks shall be made by a therapeutic radiological physicist at intervals not to exceed 1 year. Quality assurance checks shall include, but need not be limited to, determination of the following:

A) The radiation output for a set of operating conditions specified by the therapeutic radiological physicist;

B) The coincidence of the radiation field and the field indicated by the beam-limiting device, except for systems equipped with fixed diaphragms or cones; and

C) The therapeutic radiological physicist shall establish criteria for quality assurance check measurements and shall determine corrective actions to be implemented if the criteria are exceeded.

AGENCY NOTE: Quality assurance checks should be performed at a frequency which is appropriate for the particular therapy system, as determined by the therapeutic radiological physicist and based on the history of stability of the radiation output of the machine. A suggested frequency is one that would result in a quality assurance check being performed at least once during a typical patient's course of treatment.

3) Whenever service or maintenance is performed on the therapy system, a therapeutic radiological physicist shall be notified and shall determine whether a calibration or quality assurance check is necessary to verify the characteristics of the beam.

4) Measurements of the radiation output of the x-ray therapy system shall be performed using a dosimetry system that has been calibrated by a calibration laboratory accredited by the American Association of Physicists in Medicine (AAPM). Calibration of the dosimetry system shall have been performed using a radiation beam of comparable half-value layer to the x-ray system to be calibrated. The dosimetry system shall meet one of the two conditions below:

A) The calibration of the dosimetry system shall have been performed within the previous 2 years and after any servicing that may have affected the calibration of the dosimetry system; or

B) The dosimetry system shall have been calibrated within the previous 4 years and shall have been subjected to a protocol which

provides for checks of dosimetry constancy and provides for corrective action when results deviate by more than two percent from the expected values.

5) The registrant shall maintain at the facility records of machine calibrations, quality assurance checks and instrument calibrations for inspection by the Agency~~Department~~ for a period of 5 years. Records to be maintained by the registrant shall include, but need not be limited to, the following:

A) Records of machine calibrations and quality assurance checks shall include identification of the x-ray therapy system, radiation measurements, the date the measurements were performed and the signature of the therapeutic radiological physicist who performed the measurements.

B) Instrument calibration records shall include the date of the last calibration and identity of the calibration laboratory. If a dosimetry system has been subjected to a protocol as described in subsection (d)(4)(B) of this Section, records shall be maintained that show the date and results of each constancy check performed on the system.

e) Operating Procedures

1) No x-ray therapy system shall be left unattended unless the system is secured against unauthorized use.

2) When a patient must be held in position for radiation therapy, mechanical supporting or restraining devices shall be used.

3) Other than the patient, no individual shall be in the therapy room unless such individual is protected by a barrier sufficient to meet the requirements of 32 Ill. Adm. Code 340.

4) Other than the patient, no individual shall be in the therapy room during exposures from x-ray therapy systems operating above 150 kVp.

5) The x-ray therapy system shall not be used for treatment of patients unless

the operator can maintain visual observation of the patient and audible communication with the patient.

6) On contact therapy systems, a shield of at least 0.5 millimeter lead equivalency at 100 kVp shall be positioned over the entire useful beam exit port during periods when the tube is energized and the beam is not being used.

7) The tube housing assembly shall not be held by hand during operating unless the x-ray therapy system is designed to require such holding and the peak tube potential of the system does not exceed 50 kilovolts. In such cases, the person holding the tube shall wear protective gloves and apron of not less than 0.5 millimeter lead equivalency at 100 kVp.

(Source: Amended at 31 Ill. Reg. _____, effective _____)

Section 360.120 Therapy Systems Operating at 1 MeV or Greater

In addition to the provisions of Sections 360.10 through 360.30 of this Part, the requirements of this Section apply to particle accelerator systems operating at energies of 1 MeV or greater. Accelerator systems capable of producing radioactive materials in excess of the exempt quantities specified in 32 Ill. Adm. Code 330.Appendix B shall also be licensed pursuant to the provisions~~provision~~ of 32 Ill. Adm. Code 330.

a) Facility Design

1) The registrant shall consult a therapeutic radiological physicist in the design of a particle accelerator installation.

2) Shielding Requirements

A) Each accelerator installation shall be provided with such primary and secondary barriers as are necessary to assure compliance with 32 Ill. Adm. Code 340.

B) Facility design information for all accelerators installed after October 15, 1993 shall be submitted to the Agency~~Department~~ for review prior to installation. Information submitted to the Agency~~Department~~ shall include, but need not be limited to, the

following:

i) Name and address of the planned installation;

ii) Name, address and telephone number of the therapeutic radiological physicist who was consulted in the design of the installation;

iii) A scale drawing that includes the location of the accelerator, control panel and doors to the room;

iv) The structural composition and thickness of all walls, doors, partitions, floor and ceiling of the installation;

v) The occupancy of areas adjacent to the installation;

vi) Calculations that demonstrate the adequacy of the amount of shielding specified for each primary and secondary protective barrier; and

vii) Projected weekly dose rates in areas adjacent to the installation.

3) Interlock. An interlock shall be installed on each door of the therapy room. The interlock shall be wired into the electrical circuit in such a manner that when the door is opened for any reason, the generation of radiation beams will automatically be terminated and irradiation can be resumed only by manually resetting the controls on the control panel after the door is closed.

4) Warning lights that indicate when the beam is on shall be provided in a readily observable position near the outside of all access doors to the therapy room.

5) Viewing System. Windows, mirrors, closed-circuit television or an equivalent system shall be provided to permit continuous visual observation of the patient during irradiation and shall be located so that the operator can observe the patient from the control panel.

AGENCY NOTE: When the primary viewing system is electronic, a back-up system should be available for use in the event of failure of the primary system in order to ensure compliance with the requirements of subsection (g)(1)(H) of this Section.

6) The facility design shall permit two-way aural communications between the patient and the operator at the control panel.

7) Signs required by 32 Ill. Adm. Code 340.920 shall be posted in the facility.

8) The control panel shall be outside the therapy room.

9) The facility design shall include emergency off buttons, at locations that allow shutting off the machine from inside the therapy room and at the control panel.

10) The doors to the therapy room shall be designed to allow opening from the inside at all times and shall be capable of being opened manually.

b) Equipment Requirements

1) Leakage radiation to the patient area shall be measured for each accelerator. Measurements shall be repeated following maintenance or service performed on the accelerator, as determined by a therapeutic radiological physicist.

A) For operating conditions producing maximum leakage radiation, the absorbed dose due to leakage radiation, excluding neutrons, at any point in a circular plane of 2 meters radius centered on and perpendicular to the central axis of the beam at the isocenter or normal treatment distance and outside the maximum useful beam size shall not exceed 0.1 percent of the maximum absorbed dose of the unattenuated useful beam measured at the point of intersection of the central axis of the beam and the plane surface. Radiation measurements shall be averaged over an area up to but not exceeding 100 square centimeters.

B) Records of the most recent radiation leakage measurements and the

machine parameters used during the survey shall be maintained at the facility for inspection by the Agency~~Department~~.

2) Beam-Limiting Devices. Adjustable or interchangeable beam-limiting devices shall transmit no more than two percent of the useful beam at the normal treatment distance for the portion of the useful beam that is to be attenuated by the beam-limiting device. The neutron component of the useful beam shall not be subject to this requirement. This requirement does not apply to auxiliary blocks or materials placed in the useful beam to shape the useful beam to the individual patient.

3) Source-Skin Distance (SSD) Indication

A) Means shall be provided to indicate the SSD.

B) The SSD shall be indicated in centimeters and/or inches and the measured SSD shall correspond to the indicated value to within 0.5 percent.

4) Filters

A) Each filter that is removable from the system shall be clearly marked with an identification number. Documentation available at the control panel shall contain a description of the filter. For wedge filters, the wedge angle and maximum design field size shall appear on the wedge or wedge tray.

B) If the machine calibration measurements required by subsection (d) of this Section relate exclusively to operation with an x-ray field flattening filter or electron beam scattering filter in place, such filters shall be removable from the machine only by the use of tools.

C) Equipment utilizing a system of wedge filters, interchangeable field flattening filters or interchangeable beam scattering filters shall meet the following requirements:

i) The equipment shall have an interlock that prevents irradiation if any filter selection operation carried out in the

therapy room is not consistent with the selection of filter, beam type or beam energy at the control panel; and

ii) The equipment shall have an interlock system that prevents irradiation if any selected filter is not in the correct position.

5) Beam Monitoring System. All accelerator systems shall be provided with a beam monitoring system in the radiation head capable of monitoring and terminating irradiation.

A) Each beam monitoring system shall have a display at the treatment control panel which shall register accumulated monitor units.

B) The beam monitoring system shall terminate irradiation when the preselected number of monitor units has been detected by the system.

C) Accelerator systems manufactured after October 15, 1993 shall be equipped with a primary and a secondary beam monitoring system. Each beam monitoring system shall be independently capable of monitoring and terminating irradiation.

D) For units with a secondary beam monitoring system, the primary beam monitoring system shall terminate irradiation when the preselected number of monitor units has been detected. The secondary beam monitoring system shall terminate irradiation if the primary system fails.

E) An interlock device shall prevent irradiation if any beam monitoring system is inoperable.

F) In the event of power failure, the display information required in subsection (b)(5)(A) of this Section, shall be retrievable in at least one system for 20 minutes.

6) Beam Symmetry. For equipment equipped with beam bending magnets, the symmetry of the radiation beam in two orthogonal directions shall be monitored before the beam passes through the beam-limiting device. The

equipment shall provide means of terminating irradiation automatically if the difference in dose rate between one region and another region exceeds criteria specified by the manufacturer.

7) Control Panel

A) Selection and Display of Monitor Units

i) Irradiation shall not be possible until a selection of a number of monitor units has been made at the control panel.

ii) The selected number of monitor units shall be displayed at the control panel until reset.

iii) After completion of irradiation, it shall be necessary to reset the accumulated beam monitor units before treatment can be restarted.

B) Termination of Irradiation. It shall be possible to terminate irradiation and equipment movements at any time from the operator's position at the control panel.

C) Selection of Radiation Type. Equipment capable of both photon and electron therapy shall meet the following requirements:

i) Irradiation shall not be possible until the radiation type has been selected and displayed at the control panel.

ii) An interlock shall be provided to ensure that the machine will emit only the radiation type that has been selected.

iii) An interlock shall be provided to prevent irradiation with x-rays, except to obtain port films, when electron applicators are installed.

iv) An interlock shall be provided to prevent irradiation with electrons if accessories specific for x-ray therapy are installed.

D) Selection~~Section~~ of Radiation Energy. Equipment capable of producing radiation beams of different energies shall meet the following requirements:

i) Irradiation shall not be possible until a selection of energy has been made at the control panel.

ii) An interlock shall be provided to ensure that the machine will emit only the nominal energy of radiation that has been selected.

iii) The nominal value of the energy selected shall be displayed at the treatment control panel.

E) Selection of Stationary or Moving Beam Therapy. Equipment capable of both stationary and moving beam therapy shall meet the following requirements:

i) Irradiation shall not be possible unless either stationary therapy or moving beam therapy has been selected at the control panel. The selection of stationary therapy may be performed as a default selection if moving beam therapy is not selected.

ii) An interlock shall be provided to ensure that the machine will operate only in the mode that has been selected.

iii) An interlock shall be provided to terminate irradiation if the gantry fails to move properly during moving beam therapy.

iv) Means shall be provided to prevent movement of the gantry during stationary therapy.

v) The mode of operation shall be displayed at the control panel.

F) Timers. A timer shall be provided with a display at the treatment control panel, as a back-up device to the beam monitoring system.

i) The timer shall permit presetting and determination of exposure times.

ii) The timer shall be a cumulative timer which activates with the production of radiation and retains its reading after irradiation is interrupted or terminated.

iii) The timer shall terminate irradiation when a preselected time has elapsed if the beam monitoring system has not previously terminated irradiation. If set at zero, the timer shall not permit irradiation.

G) Security. The control panel shall be capable of being locked to prevent unauthorized use.

c) Radiation Protection Survey. A radiation protection survey shall be performed by a therapeutic radiological physicist on each accelerator. The registrant shall maintain at the facility a copy of the most recent radiation protection survey report for review by the Agency~~Department~~. Radiation protection surveys shall meet the following additional requirements:

1) For each accelerator installed after October 15, 1993, a radiation protection survey shall be performed by a physicist before the system is first used for irradiation of a patient. The physicist who performs the radiation protection survey shall be a person who did not consult in the design of the accelerator installation (see subsection (a) of this Section) and is not employed by or within any corporation or partnership with the person who consulted in the design of the installation.

2) A radiation protection survey shall be performed by a physicist after any change in the accelerator or facility that might produce a radiation hazard. Such survey shall be performed before the system is used to treat patients.

3) The survey report shall include, but need not be limited to, the following:

A) A diagram of the facility which details building structures and the position of the control panel, accelerator and associated equipment;

B) A description of the accelerator system including the manufacturer, model number, beam type and beam energy range;

C) A description of the instrumentation used to determine radiation measurements, including the date and source of the most recent calibration for each instrument used;

D) Conditions under which radiation measurements were taken;

E) Survey data including:

i) Projected weekly dose equivalent in areas adjacent to the therapy room; and

ii) A description of workload, use and occupancy factors employed in determining the projected weekly dose equivalent.

4) The registrant shall retain a copy of the radiation protection survey report and a copy of the report shall be provided to the Agency~~Department~~ within 30 days after completion of the survey.

5) Any deficiencies detected during the radiation protection survey that would constitute or result in a violation of 32 Ill. Adm. Code 340 shall be corrected prior to using the machine for treatment of patients.

6) The facility shall be operated in compliance with any limitations indicated by the therapeutic radiological physicist as a result of the radiation protection survey.

d) Machine Calibration. Calibration measurements shall be performed on each accelerator system by a therapeutic radiological physicist before the therapy system is first used for irradiation of a patient. Subsequent calibrations shall be performed at intervals not exceeding 1 year.

1) Calibration measurements shall include, but need not be limited to, the following determinations:

A) Verification that the equipment is operating in compliance with the

design specifications concerning the light localizer, variation in the axes of rotation for the table, gantry and jaw system and the beam flatness and symmetry at the specified depth;

B) The absorbed dose rate at various depths in water for the range of field sizes used, for each beam type and energy;

C) The uniformity of the radiation field and any dependency upon the direction of the beam;

D) Verification that existing depth-dose data and isodose charts applicable to the specific machine continue to be valid or are updated to existing machine conditions; and

E) Verification of transmission factors for all accessories such as wedges, shadow trays and compensators, as applicable.

2) Calibration radiation measurements shall be performed using a dosimetry system that has been calibrated by a calibration laboratory accredited by the American Association of Physicists in Medicine (AAPM), and meets the requirements of either subsection (d)(2)(A) or (B) of this Section:

A) The calibration shall have been performed within the previous 2 years and after any servicing that may have affected calibration of the dosimetry system; or

B) The dosimetry system shall have been calibrated within the previous 4 years and shall have been:

i) Compared at annual intervals following the calibration to a dosimetry system with calibration obtained within the previous 2 years from a calibration laboratory accredited by the AAPM, and the results of the comparison indicate the calibration factor has not changed by more than two percent; or

ii) Subjected to a testing protocol that has been established by a therapeutic radiological physicist and that provides for checks of dosimetry constancy and provides for corrective

action when results deviate more than two percent from the expected values.

AGENCY NOTE: Redundancy is a basic tenet of radiation dosimetry, therefore the therapeutic radiological physicist should establish a program of inter-comparison and constancy testing of calibrated dosimetry instruments to assure, as much as possible, the accuracy, reliability and reproducibility of the measurements performed with those instruments.

3) Calibration of the radiation output of the accelerator shall be performed in accordance with:

A) The protocol of Task Group 21, Radiation Therapy Committee, American Association of Physicists in Medicine (AAPM), entitled "A Protocol for the Determination of Absorbed Dose from High-Energy Photon and Electron Beams" published in Medical Physics, Volume 10, pages 741-771 (1983), exclusive of subsequent amendments or editions; or

B) The protocol of the Scientific Committee on Radiation Dosimetry of the AAPM, entitled "Protocol for the Dosimetry of X and Gamma Ray Beams with Maximum Energies Between 0.6 and 50 MeV", published in Physics, Medicine, and Biology, Volume 16, pages 379-396 (1971), exclusive of subsequent amendments or editions; or

C) Other machine calibration protocols provided that the registrant has submitted the protocols to the Agency~~Department~~ and the protocols cover the same topics as those contained in subsections (d)(3)(A) and (B) of this Section.

AGENCY NOTE: Copies of the two protocols referenced in subsections (d)(3)(A) and (B)~~above~~ are available for public inspection at the Illinois Emergency Management Agency~~Department of Nuclear Safety~~, 1035 Outer Park Drive, Springfield, Illinois. The protocols may also be obtained directly from the AAPM, One Physics Ellipse, College Park MD 20740-

3846.

4) The radiation output of each therapy system shall be independently verified at intervals not to exceed 2 years. Independent verification shall consist of:

A) Verification of the machine output by a therapeutic radiological physicist who is not employed at the facility and does not perform the annual calibration; or

B) Alternate methods of verification of machine output, such as the use of mailed dosimetry devices, that use devices and procedures approved by the AAPM.

5) Machine calibration records shall include identification of the accelerator calibrated, the results of the tests specified in subsection (d)(1) of this Section and shall be signed and dated by the therapeutic radiological physicist who performed the calibration.

6) The registrant shall maintain at the facility, for a period of 5 years, records of machine calibrations, instrument calibrations and independent verifications of machine output for inspection by the Agency~~Department~~.

e) Quality Assurance Checks. A quality assurance (QA) check shall be performed by a therapeutic radiological physicist on each therapy system each calendar month. The interval between QA checks shall not exceed 45 days. QA checks shall also be performed after any change which could affect the radiation output, spatial distribution or other characteristics of the therapy beam, as determined by the physicist. Quality assurance checks shall also meet the following requirements:

1) Quality assurance checks shall include determination of:

A) The radiation output for a set of operating conditions specified by a therapeutic radiological physicist; and

B) The coincidence of the radiation field and the field indicated by the localizing device.

2) Radiation measurements shall be obtained using a dosimetry system that:

A) Meets the requirements of subsection (d)(2) of this Section; or

B) Has been directly compared by a therapeutic radiological physicist within the previous year with a dosimetry system which meets the requirements of subsection (d)(2) of this Section.

3) The therapeutic radiological physicist shall establish criteria for quality assurance check measurements and shall determine corrective actions to be implemented if the criteria are exceeded.

4) The registrant shall retain a record of quality assurance check measurements for inspection by the Agency~~Department~~ for a period of 5 years. The record shall include the date of the quality assurance check, identification of the accelerator, results of the quality assurance check measurements and the signature of the individual who performed the quality assurance check.

f) Quality Control. A comprehensive quality control program shall be implemented as specified by a therapeutic radiological physicist and shall meet the following requirements:

1) The program shall be designed to test the operation and performance of the accelerator in order to maintain radiation safety and clinical reliability. The program shall include as a minimum the items listed in Section 360.Appendix E of this Part.

2) The physicist shall specify the tolerance and frequency of performance for each item of the quality control program.

3) The physicist shall specify what actions are to be taken for any item exceeding the specified tolerance.

4) The physicist shall review, sign and date the results of the quality control program each calendar month.

AGENCY NOTE: The elements of a comprehensive quality control program are described in Report No. 13 published by the AAPM, entitled "Physical Aspects of

Quality Assurance in Radiation Therapy" (1984). A copy of this report is available for public inspection at the Illinois Emergency Management Agency~~Department of Nuclear Safety~~, 1035 Outer Park Drive, Springfield, Illinois. Report No. 13 may also be obtained directly from the AAPM, One Physics Ellipse, College Park MD 20740-3846.

g) Operating Procedures. The registrant shall have a therapeutic radiological physicist establish written operating and emergency procedures and shall ensure that the procedures are implemented before the accelerator is used for treatment of patients. Operators of accelerators shall receive training in the application of the procedures before using the accelerator to irradiate patients. A copy of the current operating and emergency procedures shall be maintained at the treatment control panel for use and review.

1) Operating procedures to be implemented shall include instructions that:

A) The accelerator is used in such a manner that patients, workers and the general public are protected from radiation hazards and the provisions of 32 Ill. Adm. Code 340 are met;

B) No accelerator shall be left unattended unless it is secured against unauthorized use;

C) The safety interlock system shall not be used to turn off the beam except in an emergency;

D) The safety interlocks and warning systems required in subsections (a)(3), (a)(4) and (a)(9) of this Section shall be tested for proper operation at monthly intervals;

E) Mechanical supporting or restraining devices shall be used when a patient must be held in position for radiation therapy;

F) No individual other than the patient shall be in the therapy room during irradiation;

G) Start-up procedures for the accelerator, specified by the therapeutic radiological physicist, shall be performed daily prior to treatment of patients; and

H) The accelerator shall not be used for treatment of patients unless the operator can maintain visual observation of the patient and audible communication with the patient.

2) Emergency procedures shall include instructions for alternate methods for termination of irradiation and machine movements.

AGENCY NOTE: The operating and emergency procedures should contain as a minimum the machine manufacturer's operations manual for the accelerator.

3) Operating and emergency procedures shall include instructions for contacting the therapeutic radiological physicist when operational problems or emergencies occur and the actions that are to be taken until the physicist can be contacted.

h) Machine Maintenance. The therapeutic radiological physicist shall establish accelerator maintenance procedures that meet the following requirements:

1) Whenever service or maintenance is performed on the accelerator, a therapeutic radiological physicist shall be notified of such service or maintenance.

2) Following completion of service or maintenance involving radiation beam generation, beam steering or monitoring of the beam, but before the accelerator is again used for treatment of patients, the therapeutic radiological physicist shall review the service or maintenance report and shall determine whether a calibration or quality assurance check is necessary to verify the characteristics of the beams~~beam(s)~~. If the therapeutic radiological physicist determines that a calibration or quality assurance check is necessary, the calibration or quality assurance check shall be performed before the accelerator is again used for treatment of patients.

3) The therapeutic radiological physicist shall establish the frequency of routine maintenance and ensure that records of all service and maintenance performed on the machine are maintained at the facility.

4) The therapeutic radiological physicist shall sign and date records of all service and maintenance performed on the machine.

5) The therapeutic radiological physicist shall specify the qualifications of maintenance personnel and prohibit non-qualified personnel from repairing the machine or adjusting parameters on the machine.

6) Circuit diagrams of the accelerator and interlock systems shall be maintained at the facility and kept current.

i) Quality Management Program. Each registrant shall develop, implement, and maintain a quality management program to provide high confidence that radiation will be administered as directed by the physician. The quality management program shall address, as a minimum, the following specific objectives:

1) Written Directives. A written directive must be dated and signed by a physician prior to the administration of radiation.

A) A written directive must contain the patient or human research subject's name, the type and energy of the beam, the total dose, dose per fraction, treatment site, and number of fractions.

B) A written revision to an existing written directive may be made provided that the revision is dated and signed by a physician prior to the administration of the external beam dose, or the next fractional dose.

C) An oral revision to an existing written directive is acceptable provided that:

i) a delay in providing a written revision would jeopardize the patient's health; and

ii) the oral revision is documented as soon as possible in writing in the patient's record; and

iii) a revised written directive is signed by a physician within 48 hours after the oral revision.

D) The registrant shall retain a copy of each written directive for 3 years.

2) Procedures for Administrations. The registrant shall develop, implement, and maintain written procedures to provide high confidence that:

A) Prior to the administration of each course of radiation treatments, the patient's or human research subject's identity is verified by more than one method as the individual named in the written directive;

B) Each administration is in accordance with the written directive;

C) External beam radiation therapy final plans of treatment and related calculations are in accordance with the respective written directives;

D) Any unintended deviation from the written directive is identified and evaluated, and appropriate action is taken; and

E) The registrant retains a copy of the procedures for administrations for three years.

(Source: Amended at 31 Ill. Reg. _____, effective _____)

ILLINOIS EMERGENCY MANAGEMENT AGENCY

NOTICE OF PROPOSED AMENDMENTS

Section 360.APPENDIX A Medical Radiographic Entrance Exposure Measurement Protocol

The following protocol shall be used for measuring and calculating entrance skin exposures (ESE) for routine diagnostic examinations. Radiation measurements shall be performed with a calibrated radiation measuring device that is sufficiently sensitive to determine compliance with the criteria specified in Section 360.60(e) of this Part. The instrument shall have been calibrated within the previous 12 months with devices which have no more than a three-step (tertiary) calibration, traceable to the National Institute of Standards and Technology. Patients are not involved in the measurement protocol.

a) Position the x-ray tube at the source-image receptor distance (SID) routinely used and adjust the collimation to the active portion of a radiation measuring device.

b) Measure the distance from the x-ray source to the source against which the patient rests. Subtract the thickness of the patient to obtain the source-skin distance (SSD). The standard patient thickness for each projection to be measured shall be the following:

Projection	Thickness (cm)
Chest (PA), Grid	23
Chest (PA), Non-Grid	23
Abdomen (KUB)	23
Lumbo-Sacral Spine (AP)	23
Cervical Spine (AP)	13
Skull (lateral)	15
Foot (D/P)	8

c) Place a radiation measuring device in the center of the useful beam, measure and record the distance from the source to the device (SDD). Use of a test stand to position the device away from the table will reduce backscatter contribution. Placing the radiation measuring device at the actual source-skin distance (SSD) will accomplish this and allow direct reading of the ESE.

d) Set the exposure technique as follows:

1) For non-phototimed x-ray systems, set the controls to the exposure technique used by the x-ray operator for the standard patient thickness

specified in subsection (b) of this Section.

2) For phototimed x-ray systems, set the controls to the exposure technique used by the x-ray operator for the standard patient thickness specified in subsection (b) of this Section, and use one of the two methods below:

A) Place an appropriate phantom (simulating body attenuation) in the useful beam between the radiation measuring device and the radiographic tabletop; or

B) Set an appropriate exposure technique in the manual mode (without activation of the phototimer).

AGENCY NOTE: Specifications for appropriate phantoms are included in the American Association of Physicists in Medicine (AAPM) Report No. 31, entitled "Standardized Methods for Measuring Diagnostic X-Ray Exposures" (July 1990). ~~AGENCY NOTE:~~ A copy of this report is available for public inspection at the Illinois Emergency Management Agency~~Department of Nuclear Safety~~, 1035 Outer Park Drive, Springfield, IL. Copies of this report may also be obtained from the AAPM, One Physics Ellipse, College Park MD 20740-3846.

e) Make a radiographic exposure (without patient) and record the reading obtained from the radiation measuring device

f) Calculate the entrance skin exposure for the specific examination, using the radiation exposure reading from subsection (e) of this Section and the equation in this subsection (f) below (if a direct result was not obtained with the dosimeter at the SSD). The entrance skin exposure equals the product of the radiation exposure reading from subsection (e) of this Section multiplied by the square of the ratio of the SDD, to the SSD. This expression is mathematically represented by the equation below (if a direct result was not obtained with the dosimeter at the SSD):

$$\text{ESE} = (\text{Dosimeter Reading}) \times \left[\frac{\text{SDD}}{\text{SSD}}\right]^2$$

where: SDD = source-radiation measuring device distance

SSD = source to skin distance

g) Compare the results of the calculation from subsection (f) of this Section with the criteria specified in Section 360.60(e) of this Part to determine compliance.

AGENCY NOTE: There are many different techniques for measuring ESE that~~which~~ may result in significant differences in measured values. Factors that can cause variations include instrument calibration, backscatter, collimation, estimation of focal spot location, choice of phantom, location of dosimeter in the primary beam, etc. Because of these variations, the procedure for determining the ESE should be performed with strict attention to each detail noted above.

(Source: Amended at 31 Ill. Reg. _____, effective _____)

DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

NOTICE OF PROPOSED AMENDMENTS

1) Heading of the Part: Traditional Long-Term Care Insurance

2) Code Citation: 50 Ill. Adm. Code 2012

3)

Section Numbers:	Proposed Action:
2012.10	Amendment
2012.20	Amendment
2012.30	Amendment
2012.40	Amendment
2012.50	Amendment
2012.55	Amendment
2012.60	Amendment
2012.62	Amendment
2012.64	Amendment
2012.65	Amendment
2012.70	Amendment
2012.80	Amendment
2012.83	New Section
2012.86	New Section
2012.90	Amendment
2012.95	Amendment
2012.100	Amendment
2012.110	Amendment
2012.112	Amendment
2012.115	Amendment
2012.120	Amendment
2012.121	New Section
2012.122	Amendment
2012.123	Amendment
2012.124	Renumbered, Amendment
2012.125	New Section
2012.126	Renumbered, New Section
2012.127	Amendment
2012.128	Amendment
2012.129	Amendment
2012.130	Amendment
2012.140	Amendment
2012.150	Amendment
2012.EXHIBIT A	Amendment

DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

NOTICE OF PROPOSED AMENDMENTS

2012.EXHIBIT B	Amendment
2012.EXHIBIT C	Amendment
2012.EXHIBIT D	Amendment
2012.EXHIBIT E	Repeal
2012.EXHIBIT F	Amendment
2012.EXHIBIT G	Amendment
2012.EXHIBIT H	Amendment
2012.EXHIBIT I	Amendment
2012.EXHIBIT J	Amendment
2012.EXHIBIT K	New Section

4) Statutory Authority: Implementing and authorized by Section 351A-11 of the Illinois Insurance Code [215 ILCS 5/351A-11]

5) A Complete Description of the Subjects and Issues Involved: The title of this Part will be changed and the requirements amended to bring our State rules in-line with the NAIC model on Long-Term Care regulation. These changes will include provisions that will ensure Illinois compliance with federal long-term care partnership requirements should Illinois elect to become a Partnership state. Significant changes include incontestability period and non-forfeiture provisions, producer training provisions, disclosure of availability of new long-term care services, and a new contingent benefit upon lapse provision, among others.

6) Any published studies or reports, along with the sources of underlying data, that were used when comprising this rulemaking: None

7) Will this rulemaking replace any emergency rulemaking currently in effect? No

8) Does this rulemaking contain an automatic repeal date? No

9) Does this rulemaking contain incorporations by reference? No

10) Are there any other proposed rulemakings pending on this Part? No

11) Statement of Statewide Policy Objectives: This rulemaking will not require a local government to establish, expand or modify its activities in such a way as to necessitate additional expenditures from local revenues.

DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

NOTICE OF PROPOSED AMENDMENTS

12) Time, Place, and Manner in which interested persons may comment on this proposed rulemaking: Persons who wish to comment on this proposed rulemaking may submit written comments no later than 45 days after the publication of this Notice to:

Eve Blackwell-Lewis, Senior Staff Attorney Department of Financial and Professional Regulation Division of Insurance 320 West Washington, 4th Floor Springfield, Illinois 62767-0001	or	Craig Cellini, Rules Coordinator Department of Financial and Professional Regulation 320 West Washington 3rd Floor Springfield, Illinois 62767-0001
217/782-2867		217/785-0813

13) Initial Regulatory Flexibility Analysis:

A) Types of small businesses, small municipalities and not for profit corporations affected: Insurance producers

B) Reporting, bookkeeping or other procedures required for compliance: Please review the new requirements being added to this Part.

C) Types of professional skills necessary for compliance: Insurance

14) Regulatory Agenda on which this rulemaking was summarized: January 2007

The full text of the Proposed Amendments begins on the next page:

DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

NOTICE OF PROPOSED AMENDMENTS

TITLE 50: INSURANCE
CHAPTER I: DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION~~INSURANCE~~
SUBCHAPTER z: ACCIDENT AND HEALTH INSURANCE

PART 2012
~~TRADITIONAL~~ LONG-TERM CARE INSURANCE

Section

2012.10	Purpose
2012.20	Applicability and Scope
2012.30	Definitions
2012.40	Policy Definitions
2012.50	Policy Practices and Provisions
2012.55	Unintentional Lapse
2012.60	Required Disclosure Provisions
2012.62	Required Disclosure of Rating Practices to Consumers
2012.64	Initial Filing Requirements
2012.65	Prohibition Against Post Claims Underwriting
2012.70	Minimum Standards for Home Health and Community Care Benefits in ~~Traditional~~ Long-Term Care Insurance Policies
2012.80	Requirement to Offer Inflation Protection
2012.83	Incontestestability Period
2012.86	Nonforfeiture Benefits
2012.90	Requirements for Application Forms and Replacement Coverage
2012.95	Reporting Requirements
2012.100	Filing Requirement
2012.110	Loss Ratio
2012.112	Premium Rate Schedule Increases
2012.115	Filing Requirements for Advertising
2012.120	Reserve Standards
2012.121	Producer Training Requirements
2012.122	Standards for Marketing
2012.123	Suitability
2012.124~~126~~	Prohibition Against Preexisting Conditions and Probationary Periods in Replacement Policies or Certificates
2012.125	Availability of New Services or Providers
2012.126~~124~~	Right to Reduce Coverage and Lower Premiums~~Appropriateness of Recommended Purchase~~

DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

NOTICE OF PROPOSED AMENDMENTS

2012.127 ~~Requirement to Offer~~ Nonforfeiture Benefit Requirement
2012.128 Standards for Benefit Triggers
2012.129 Additional Standards for Benefit Triggers for Qualified Long-Term Care
2012.130 Standard Format Outline of Coverage Requirements
2012.140 Requirement to Deliver Shopper's Guide
2012.150 Penalties
2012.EXHIBIT A Replacement Notice for Other Than Direct Response Solicitations
2012.EXHIBIT B Replacement Notice for Direct Response Solicitations
2012.EXHIBIT C Standard Format Outline of Coverage
2012.EXHIBIT D Rescission Reporting Format
2012.EXHIBIT E Class of Insurance – Accident and Health (Repealed)
2012.EXHIBIT F ~~Traditional~~ Long-Term Care Insurance Personal Worksheet
2012.EXHIBIT G Things You Should Know Before You Buy ~~Traditional~~ Long-Term Care Insurance
2012.EXHIBIT H ~~Traditional~~ Long-Term Care Insurance Suitability Letter
2012.EXHIBIT I Claims Denial Reporting: Long-Term Care Insurance Form~~Format~~
2012.EXHIBIT J Potential Rate Increase Disclosure
2012.EXHIBIT K Replacement and Lapse Reporting Form

AUTHORITY: Implementing and authorized by Section 351A-11 of the Illinois Insurance Code [215 ILCS 5/351A-11].

SOURCE: Adopted at 14 Ill. Reg. 10345, effective June 15, 1990; amended at 18 Ill. Reg. 2238, effective February 1, 1994; amended at 19 Ill. Reg. 2832, effective July 1, 1995; emergency amendment at 19 Ill. Reg. 8403, effective June 13, 1995; emergency expired September 1, 1995; amended at 19 Ill. Reg. 14421, effective October 3, 1995; amended at 22 Ill. Reg. 2105, effective January 6, 1998; amended at 26 Ill. Reg. 8835, effective July 1, 2002; amended at 31 Ill. Reg. _____, effective _____.

Section 2012.10 Purpose

The purpose of this Part is to implement Article XIXA of the Illinois Insurance Code, to promote the public interest, to promote the availability of ~~traditional~~ long-term care insurance coverage, to protect applicants for ~~traditional~~ long-term care insurance from unfair or deceptive sales or enrollment practices, to facilitate public understanding and comparison of long-term care insurance coverages and to facilitate flexibility and innovation in the development of ~~traditional~~ long-term care insurance.

(Source: Amended at 31 Ill. Reg. _____, effective _____)

DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

NOTICE OF PROPOSED AMENDMENTS

Section 2012.20 Applicability and Scope

a) Except as otherwise specifically provided~~ in subsection (b) of this Section~~, this Part applies to all ~~traditional~~ long-term care insurance policies including qualified long-term care insurance contracts and life insurance policies that accelerate benefits for ~~traditional~~ long-term care insurance delivered or issued for delivery in this State by any insurer on or after June 15, 1990. Certain provisions of this Part apply only to qualified long-term care insurance contracts as noted.

b) Additionally, this Part is intended to apply to policies having indemnity benefits that are triggered by activities of daily living and sold as disability income insurance, if:

1) The benefits of the disability income policy are dependent upon or vary in amount based on the receipt of ~~traditional~~ long-term care services;

2) The disability income policy is advertised, marketed or offered as insurance for ~~traditional~~ long-term care services; or

3) Benefits under the policy may commence after the policyholder has reached Social Security's normal retirement age unless benefits are designed to replace lost income or pay for specific expenses other than ~~traditional~~ long-term care services.

(Source: Amended at 31 Ill. Reg. _____, effective _____)

Section 2012.30 Definitions

Accelerated Long-Term Care Benefit~~Life Product~~ means a life insurance policy, contract, rider endorsement or amendment that~~which~~ contains benefits providing payment from life or endowment or annuity benefits in advance of the time they would otherwise be payable at any time during the insured's lifetime as an indemnity for ~~traditional~~ long-term care.

Applicant as defined in Section 351A-1 of the Illinois Insurance Code *means*:

in the case of an individual long-term care insurance policy, the person who seeks to contract for benefits;

in the case of a group long-term care insurance policy, the proposed certificateholder.

~~Assistive Equipment may include, but is not limited to, tangible personal property with a useful life of at least one year, expressly designed and used for increasing independent functioning in specific tasks or activities of independent living in the home that directly results in a demonstrated decrease in need for assistance from another individual in performing certain tasks or activities.~~

Certificate as defined in Section 351A-1 of the Illinois Insurance Code [215 ILCS 5/351A-1] *means any certificate issued under a group long-term care insurance policy, which policy has been delivered or issued for delivery in this State.*

Chronically Ill Individual, for all long-term care policies that are marketed as "qualified" pursuant to the Internal Revenue Code of 1986, as amended (26 USC 7702B(c)(2)(A)), means any individual who has been certified by a licensed health care practitioner as:

being unable to perform (without substantial assistance from another individual) at least 2 activities of daily living for a period of at least 90 days due to a loss of functional capacity,

having a level of disability similar (as determined under regulations prescribed by the Secretary in consultation with the Secretary of Health and Human Services) to the level of disability described in the preceding paragraph, or

requiring substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment.

The term does not include any individual otherwise meeting the requirements of this definition unless within the preceding 12-month period a licensed health care practitioner has certified that the individual meets these requirements.

Code means the Illinois Insurance Code [215 ILCS 5].

Director means the Director of the Illinois Department of Financial and Professional Regulation-Division of Insurance.

~~*Director* as defined in Section 351A-1 of the Illinois Insurance Code [215 ILCS 5/351-A-1] *means the Director of Insurance.*~~

Division means the Illinois Department of Financial and Professional Regulation~~-~~ Division of Insurance.

Exceptional Increase means only those increases filed by an insurer as exceptional for which the Director determines the need for the premium rate increase is justified due to changes in laws or regulations applicable to long-term care coverage in this State, or to increased and unexpected utilization that affects the majority of insurers of similar products.

Except as provided in Section 2012.112, exceptional increases are subject to the same requirements as other premium rate schedule increases.

The Director may request a review by an independent actuary or a professional actuarial body of the basis for a request that an increase be considered an exceptional increase.

The Director, in determining that the necessary basis for exceptional increase exists, shall also determine any potential offsets to higher claims costs.

~~Electronic Home Response Services may include, but is not limited to, services designed to provide a 24 hour per day emergency communication link to assistance outside the home for individuals so severely disabled that they are incapable of using conventional or modified communication devices such as the telephone, and who have no other persons available in the home should an emergency arise.~~

Group Long-Term Care Insurance, as defined in Section 351A-1 of the ~~Illinois Insurance~~ Code [215 ILCS 5/351A-1], *means a ~~traditional~~ long-term care insurance policy which is delivered or issued for delivery in this State and issued to one of the following:*

One or more employers or labor organizations, or to a trust or to the trustee(s) of a fund established by one or more employers or labor organizations, or a combination thereof, for employees or former

employees or a combination thereof, or for members or former members, or a combination thereof, of the labor organizations.

Any professional, trade or occupational association for its members or former or retired members, or combination thereof, if such association:

is~~Is~~ composed of individuals all of whom are or were actively engaged in the same profession, trade or occupation; and

has~~Has~~ been maintained in good faith for purposes other than obtaining insurance.

An association or a trust or the trustee(s) of a fund established, created or maintained for the benefit of members of one or more associations. Prior to advertising, marketing or offering such policy within this State, the association or associations, or the insurer of the association or associations, shall file evidence with the Director that the association or associations have at the outset a minimum of 100 members and have been organized and maintained in good faith for purposes other than that of obtaining insurance; have been in active existence for at least one year; and have a constitution and by-laws which provide that:

the association or associations hold regular meetings not less than annually to further purposes of the members;

except for credit unions, the association or associations collect dues or solicit contributions from members; and

the members have voting privileges and representation on the governing board and committees.

Thirty days after such filing the association or associations will be deemed to satisfy such organizational requirements, unless the Director makes a finding that the association or associations do not satisfy those organizational requirements.

A group other than as described in subparagraphs under the definition of Group Long-Term Care Insurance, subject to a finding by the Director that:

the~~The~~ issuance of the group policy is not contrary to the best interest of the public;

the~~The~~ issuance of the group policy would result in economies of acquisition or administration; and

the~~The~~ benefits are reasonable in relation to the premiums charged.

~~The standards to be used by the Director for determining whether a group is eligible shall include, but not be limited to: the policy shall not contain broad or misleading exclusions; premiums for group policies are less than premiums for individual policies; and the loss ratio complies with the requirements of Section 2012.110.~~

~~Homemaker Service may include, but is not limited to, nonmedical support provided by trained and professionally supervised homemakers to maintain, strengthen and safeguard the functioning of individuals in their own homes.~~

Incidental, as used in Section 2012.112(j) of this Part, means that the value of the long-term care benefit provided is less than 10% of the total value of the benefits provided over the life of the policy. These values shall be measured as of the date of issue.

Insurer includes: insurance companies; fraternal benefit societies; nonprofit health, hospital, and medical service corporations; prepaid health plans; health maintenance organizations or any similar organization.

~~Maintenance Home Health Care Services may include, but is not limited to, medically related services provided in the home in accordance with services prescribed by a physician. Specific components of maintenance home health care may include: nursing services, physical, respiratory or speech therapy; medical/health care services provided by a home health care aide.~~

Maintenance or Personal Care Services, within the meaning of the internal Revenue Code of 1986, as amended (26 USC 7702B(c)(3)), means any care the primary purpose of which is the provision of needed assistance with any of the disabilities as a result of which the individual is a chronically ill individual (including the protection from threats to health and safety due to severe cognitive

impairment).

Policy, as defined in Section 351A-1 of the Illinois Insurance Code [215 ILCS 5/351A-1], *means any policy, contract, subscriber agreement, rider or endorsement delivered or issued for delivery in this State by an insurer, fraternal benefit society, non-profit health, hospital, or medical service corporation, prepaid health plan, health maintenance organization or any similar organization*.

Qualified Actuary means a member in good standing of the American Academy of Actuaries.

Qualified Long-Term Care Contract means any insurance contract that provides only coverage of qualified long-term care services and is guaranteed renewable, and does not provide for cash surrender value or other money that can be paid, assigned, pledged or borrowed. Dividends and refunds, other than refunds paid upon death of the insured or complete surrender or cancellation of the contract, may only be used to reduce future premiums or increase future benefits. Qualified long-term care contracts do not pay or reimburse expenses that are reimbursable under Medicare, except when Medicare is a secondary payor or when the contract makes payments per diem or on another periodic basis without regard to actual expenses, and must satisfy consumer protective provisions for long-term care insurance.

Qualified Long-Term Care Services means necessary diagnostic, preventive, therapeutic, curing, treating, mitigating and rehabilitation services, and maintenance or personal care services that are required by a chronically ill individual, that are provided pursuant to a plan of care prescribed by a licensed heath care practitioner.

~~Respite Service may include, but is not limited to, temporary care for insureds aimed at relieving stress for the insured's families. Respite service shall be provided for vacation, rest, errands, family crisis or emergency.~~

Similar Policy Forms means all of the long-term care insurance policies and certificates issued by an insurer in the same long-term care benefit classification as the policy form being considered. Certificates of groups that meet the definition of "Group Long-Term Care Insurance" found in Section 351A-1(e)(1) of the Code are not considered similar to certificates or policies otherwise issued

as long-term care insurance, but are similar to other comparable certificates with the same long-term care benefit classifications. For purposes of determining similar policy forms, long-term care benefit classifications are defined as follows: institutional long-term care benefits only, non-institutional long-term care benefits only, or comprehensive long-term care benefits.

~~*Traditional*~~ *Long-Term Care Insurance*, as defined in Section 351A-1 of the ~~Illinois Insurance~~ Code [215 ILCS 5/351A-1], *means any accident and health insurance policy or rider advertised, marketed, offered or designed to provide coverage for not less than 12 consecutive months for each covered person on an expense incurred, indemnity, prepaid or other basis for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital. The~~~~Such~~ *term includes group and individual annuities and life insurance policies or riders which provide directly or which supplement long-term care insurance. Such term also includes a policy or rider which provides for payment of benefits based upon cognitive impairment or the loss of function capacity. Long-term care insurance may be issued by insurers,~~~~;~~ *fraternal benefit societies,~~~~;~~ *nonprofit health, hospital, and medical service corporations,~~~~;~~ *prepaid health plans,~~~~;~~ *health maintenance organizations or any similar organization, to the extent they are otherwise authorized to issue life or health insurance. Long-term care insurance shall not include any insurance policy which is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income* or related asset-*protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage. Long-term care insurance may include benefits for care and treatment in accordance with the tenets and practices of any established church or religious denomination which teaches reliance on spiritual treatment through prayer for healing.*

(Source: Amended at 31 Ill. Reg. _____, effective _____)

Section 2012.40 Policy Definitions

a) No long-term care insurance policy delivered or issued for delivery in this State shall use the terms set forth below, unless the terms are defined in the policy and the definitions satisfy the following requirements.~~No insurance policy or certificate may be advertised, solicited, delivered or issued for delivery in this~~

~~State as a traditional long-term care policy unless the policy or subscriber contract contains definitions or terms that are not more restrictive than the requirements of this Section.~~

"Activities of Daily Living" means at least bathing, continence, dressing, eating, toileting and transferring.

"Acute Condition" means a condition that causes the individual to be medically unstable. Such individual requires frequent monitoring by medical professionals, such as physicians and registered nurses, in order to maintain his or her health status.

"Adult Day Care" means a program for 6 or more individuals, of social and health-related services provided during the day in a community group setting for the purpose of supporting frail, impaired elderly or other disabled adults who can benefit from care in a group setting outside the home.

~~All providers of services, including but not limited to skilled nursing facility, intermediate care facility, convalescent nursing home, personal care facility, and home care agency shall be defined in relation to the services and facilities required to be available and the licensure or degree status of those providing or supervising the services. The definition may require that the provider be appropriately licensed or certified.~~

"Assistive Equipment" may include, but is not limited to, tangible personal property with a useful life of at least one year, expressly designed and used for increasing independent functioning in specific tasks or activities of independent living in the home that directly results in a demonstrated decrease in need for assistance from another individual in performing certain tasks or activities.

"Bathing" means washing oneself by sponge bath, or in either a tub or shower, including the task of getting into or out of the tub or shower.

~~"Chronically Ill Individual", for all traditional long-term care policies that are marketed as "qualified" pursuant to the Internal Revenue Code of 1986, as amended (26 USC 7702B(c)(2)(A)), the term "chronically ill individual" means any individual who has been certified by a licensed health care practitioner as:~~

~~i) being unable to perform (without substantial assistance from another~~

~~individual) at least 2 activities of daily living for a period of at least 90 days due to a loss of functional capacity,~~

~~ii)~~ ~~requiring substantial supervision to protect such individual from threats to health and safety due to severe cognitive impairment.~~

~~Such term shall not include any individual otherwise meeting the requirements of the preceding sentence unless within the preceding 12-month period a licensed health care practitioner has certified that such individual meets such requirements.~~

"Cognitive Impairment" means a deficiency in a person's short- or long-term memory, orientation as to person, place and time, deductive or abstract reasoning, or judgment~~judgement~~ as it relates to safety awareness.

"Continence" means the ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).

"Dressing" means putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.

"Eating" means feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.

"Electronic Home Response Services" may include, but are not limited to, services designed to provide a 24 hour per day emergency communication link to assistance outside the home for individuals so severely disabled that they are incapable of using conventional or modified communication devices such as the telephone, and who have no other persons available in the home should an emergency arise.

~~"Exceptional Increase" means only those increases filed by an insurer as exceptional for which the Director determines the need for the premium rate increase is justified:~~

~~Due to changes in laws or regulations applicable to traditional long-term care coverage in this State; or~~

~~Due to increased and unexpected utilization that affects the majority of insurers of similar products.~~

~~Except as proved in Section 2012.112, exceptional increases are subject to the same requirements as other premium rate schedule increases.~~

~~The Director may request a review by an independent actuary or a professional actuarial body of the basis for a request that an increase be considered an exceptional increase.~~

~~The Director, in determining that the necessary basis for exceptional increase exists, shall also determine any potential offsets to higher claims costs.~~

"Hands-on Assistance" means physical assistance (minimal, moderate or maximal) without which the individual would not be able to perform the activity of daily living.

"Home Health Care Services" means medical and nonmedical services provided to ill, disabled or infirmed~~informed~~ persons in their residences. Examples of such services may include but are not limited to homemaker services, assistance with activities of daily living and respite care services.

"Homemaker Service" may include, but is not limited to, non-medical support provided by trained and professionally supervised homemakers to maintain, strengthen and safeguard the functioning of individuals in their own homes.

~~"Incidental", as used in Section 2012.112(j), means that the value of the traditional long-term care benefit provided is less than 10% of the total value of the benefits provided over the life of the policy. These values shall be measured as of the date of issue.~~

"Licensed Health Care Practitioner" means any physician (as defined in Section 1861(r)(1) of the Social Security Act) and any registered professional nurse, licensed social worker, or other individual who meets requirements as may be prescribed by the Secretary.

"Maintenance Home Health Care Services" may include, but is not limited to, medically related services provided in the home in accordance with services

prescribed by a physician. Specific components of maintenance home health care may include: nursing services; physical, respiratory or speech therapy; and medical/health care services provided by a home health care aide.

~~"Maintenance or Personal Care Services" within the meaning of the internal Revenue Code of 1986, as amended (26 USC 7702B(c)(3)), means any care the primary purpose of which is the provision of needed assistance with any of the disabilities as a result of which the individual is a chronically ill individual (including the protection from threats to health and safety due to severe cognitive impairment).~~

"Medicare" means "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then~~then~~ Constituted or Later Amended", or "Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof", or words of similar import.~~42 U.S.C.A. Section 1395 et seq., including the "Medicare Catastrophic Coverage Act of 1988."~~

"Mental or Nervous Disorder" shall not be defined to include more than neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder~~ of any kind~~.

"Personal Care" means the provision of hands-on services to assist an individual with activities of daily living, such as bathing, eating, dressing, transferring and toileting.

"Plan of Care" in qualified plans means the specific type and frequency of all services required to maintain the individual in the community, the service providers, and the cost of services. The plan of care shall be specified in writing by a licensed health care provider.

~~"Qualified Actuary" means a member in good standing of the American Academy of Actuaries.~~

~~"Qualified Long-Term Care Contract" means any insurance contract that provides only coverage of qualified long-term care services and is: guaranteed renewable; does not provide for cash surrender value or other money that can be paid, assigned, pledged or borrowed; dividends and refunds, other than refunds paid~~

~~upon death of the insured or complete surrender or cancellation of the contract may only be used to reduce future premiums or increase future benefits; contract does not pay or reimburse expenses that are reimbursable under Medicare, except when Medicare is a secondary payor or when the contract makes payments per diem or on another periodic basis without regard to actual expenses; and consumer protective provisions for traditional long-term care insurance are satisfied.~~

~~"Qualified Long-Term Care Services" means necessary diagnostic, preventive, therapeutic, curing, treating, mitigating and rehabilitation services, and maintenance or personal care services that are required by a chronically ill individual and provided pursuant to a plan of care prescribed by a licensed heath care practitioner.~~

"Respite Service" may include, but is not limited to, temporary care for insured's aimed at relieving stress for the insureds' families. Respite service shall be provided for vacation, rest, errands, family crisis or emergency.

~~"Similar Policy Forms" means all of the traditional long-term care insurance policies and certificates issued by an insurer in the same traditional long-term care benefit classification as the policy form being considered. Certificates of groups that meet the definition found in Section 2012.30 are not considered similar to certificates or policies otherwise issued as traditional long-term care insurance, but are similar to other comparable certificates with the same traditional long-term care benefit classifications. For purposes of determining similar policy forms, traditional long-term care benefit classifications are defined as follows: institutional traditional long-term care benefits only, non-institutional traditional long-term care benefits only, or comprehensive traditional long-term care benefits.~~

"Skilled Nursing Care", "Intermediate Care", "Personal Care", "Home Care", "Specialized Care", "Assisted Living Care" and other services shall be defined in relation to the level of skill required, the nature of the care and the setting in which care must be delivered.

"Toileting" means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

"Transferring" means moving into or out of a bed, chair or wheelchair.

b) All providers of services, including but not limited to "skilled nursing facility", "intermediate care facility", "extended care facility", "specialized care providers", "assisted living facility", "convalescent nursing home", "personal care facility", and "home care agency" shall be defined in relation to the services and facilities required to be available and the licensure, certification, registration or degree status of those providing or supervising the services. When the definition requires that the provider be appropriately licensed, certified or registered, it shall also state what requirements a provider must meet in lieu of licensure, certification or registration when the state in which the service is to be furnished does not require a provider of these services to be licensed, certified or registered, or when the state licenses, certifies or registers the provider of services under another name.

(Source: Amended at 31 Ill. Reg. _____, effective _____)

Section 2012.50 Policy Practices and Provisions

a) Renewability. The terms "guaranteed renewable" and "noncancellable" shall not be used in any ~~group and individual direct response or~~ individual ~~traditional~~ long-term care insurance policy or certificate without explanatory language in accordance with the disclosure requirements of Section 2012.70 of this Part.

1) A policy issued to an individual shall not contain renewal provisions other than "guaranteed renewable" or "noncancellable". ~~No such policy or certificate issued to an individual shall contain renewal provisions less favorable to the insured than "guaranteed renewable."~~

2) The term "guaranteed renewable" may be used only when the insured has the right to continue the ~~traditional~~ long-term care insurance in force by the timely payment of premiums and when the insurer has no unilateral right to make any change in any provision of the policy or rider while the insurance is in force, and cannot decline to renew, except that rates may be revised by the insurer on a class basis.

3) The term "noncancellable" may be used only when the insured has the right to continue the ~~traditional~~ long-term care insurance in force by the timely payment of premiums during which period the insurer has no right to unilaterally make any change in any provision of the insurance or in the premium rate.

4) The term "level premium" may only be used when the insurer does not have the right to change the premium.

5) In addition to the other requirements of subsection (a) of this Section, a qualified long-term care insurance contract shall be guaranteed renewable, within the meaning of Section 7702B(b)(1)(C) of~~as required by~~ the Internal Revenue Code of 1986, as amended~~ (26 USC 7702B(b)(1)(C))~~.

b) Limitations and Exclusions. A policy may not~~No policy may~~ be delivered or issued for delivery in this State as ~~traditional~~ long-term care insurance if the~~such~~ policy limits or excludes coverage by type of illness, treatment, medical condition or accident, except as follows:

1) Preexisting conditions or diseases;

2) Mental or nervous disorders; however, this shall not permit exclusion or limitation of benefits on the basis of Alzheimer's Disease or senile dementia;

3) Alcoholism and drug addiction;

4) Illness, treatment or medical condition arising out of:

A) war or act of war (whether declared or undeclared);

B) participation in a felony, riot or insurrection;

C) service in the armed forces or units auxiliary thereto;

D) suicide (sane or insane), attempted suicide or intentionally self-inflicted injury; or

E) aviation (this exclusion applies only to non-fare paying passengers);

5) Treatment provided in a government facility (unless otherwise required by law), services for which benefits are available under Medicare or other governmental program (except Medicaid), any state or federal workers'

compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law, services provided by a member of the covered person's immediate family and services for which no charge is normally made in the absence of insurance;

6) Expenses for services or items available or paid under another traditional long-term care insurance or health insurance policy;

7) In the case of a tax qualified long-term care insurance contract, expenses for services or items to the extent that the expenses are reimbursable under Title XVIII of the Social Security Act or would be so reimbursable but for the application of a deductible or coinsurance amount;

8) This subsection (b) is not intended to prohibit exclusions and limitations by type of provider~~for payment of services provided outside the United States~~.

A) However, no long term care issuer may deny a claim because services are provided in a state other than the state of policy issue under the following conditions:

i) When the state other than the state of policy issue does not have the provider licensing, certification or registration required in the policy, but when the provider satisfies the policy requirements outlined for providers in lieu of licensure, certification or registration; or

ii) When the state other than the state of policy issue licenses, certifies or registers the provider under another name.

B) For purposes of this subsection (b)(8), "state of policy issue" means the state in which the individual policy or certificate was originally issued.

9) This subsection (b) is not intended to prohibit territorial limitations.

c) Extension of Benefits. Termination of ~~traditional~~ long-term care insurance shall be without prejudice to any benefits payable for institutionalization if such institutionalization began while the ~~traditional~~ long-term care insurance was in

force and continues without interruption after termination. Such extension of benefits beyond the period the ~~traditional~~ long-term care insurance was in force may be limited to the duration of the benefit period, if any, or to payment of the maximum benefits and may be subject to any policy waiting period, and all other applicable provisions of the policy.

d) Continuation or Conversion

1) Group ~~traditional~~ long-term care insurance issued in this State on or after February 1, 1994 shall provide covered individuals with a basis for continuation or conversion of coverage.

2) For the purposes of this Section, "a basis for continuation of coverage" means a policy provision which maintains coverage under the existing group policy when such coverage would otherwise terminate and which is subject only to the continued timely payment of premium when due. Group policies which restrict provision of benefits and services to, or contain incentives to use certain providers ~~and/~~or facilities may provide continuation benefits which are substantially equivalent to the benefits of the existing group policy. The Director shall make~~, in making~~ a determination as to the substantial equivalency of benefits, and in doing so shall take into consideration the differences between managed care and non-managed care plans, including, but not limited to, provider system arrangements, service availability, benefit levels and administrative complexity.

3) For the purposes of this Section, "a basis for conversion of coverage" means a policy provision that an individual whose coverage under the group policy would otherwise terminate or has been terminated for any reason, including discontinuance of the group policy in its entirety or with respect to an insured class, and who has been continuously insured under the group policy (and any group policy which it replaced), for at least six months immediately prior to termination, shall be entitled to the issuance of a converted policy by the insurer under whose group policy the individual is covered, without evidence of insurability.

4) For the purposes of this Section, "converted policy" means an individual policy of ~~traditional~~ long-term care insurance providing benefits identical to or benefits determined by the Director to be substantially equivalent to

or in excess of those provided under the group policy from which conversion is made. Where the group policy from which conversion is made restricts the provision of benefits and services, or contains incentives to use certain providers and/or facilities, the Director, in making a determination as to the substantial equivalency of benefits, shall take into consideration the differences between managed care and non-managed care plans, including, but not limited to, provider system arrangements, service availability, benefit levels and administrative complexity. The converted policy offered shall be on a form that is available for general sale in this State.

5) Written application for the converted policy shall be made and the first premium due, if any, shall be paid as directed by the insurer not later than thirty-one days after termination of coverage under the group policy. The converted policy shall be issued effective on the day following the termination of coverage under the group policy, and shall be guaranteed renewable.

6) Unless the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy from which conversion is made. Where the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy replaced.

7) Continuation of coverage or issuance of a converted policy shall be mandatory, except where:

A) Termination of group coverage resulted from an individual's failure to make any required payment of premium or contribution when due; or

B) The terminating coverage is replaced not later than 31 days after termination, by group coverage effective on the day following the termination of coverage:

i) Providing benefits identical to or benefits determined by the Director to be substantially similar to, or~~equivalent in~~

~~design and actuarially equivalent in value~~ in excess of, those provided by the terminating coverage; and

ii) The premium for which is calculated in a manner consistent with the requirements of subsection (d)(6) of this Section.

8) Notwithstanding any other provision of this Section, a converted policy issued to an individual who at the time of conversion is covered by another ~~traditional~~ long-term care insurance policy that~~which~~ provides benefits on the basis of incurred expenses, may contain a provision which results in a reduction of benefits payable if the benefits provided under the additional coverage, together with the full benefits provided by the converted policy, would result in payment of more than 100% of incurred expenses. Such provision shall only be included in the converted policy if the converted policy also provides for a premium decrease or refund which reflects the reduction in benefits payable.

9) The converted policy may provide that the benefits payable under the converted policy, together with the benefits payable under the group policy from which conversion is made, shall not exceed those that would have been payable had the individual's coverage under the group policy remained in force and effect.

10) Notwithstanding any other provision of this Section, any insured individual whose eligibility for group ~~traditional~~ long-term care coverage is based upon his or her relationship to another person, shall be entitled to continuation of coverage under the group policy upon termination of the qualifying relationship by death or dissolution of marriage.

11) For the purposes of this Section, ~~:~~ a "Managed-Care Plan" is a health care or assisted living arrangement designed to coordinate patient care or control costs through utilization review, case management or use of specific provider networks.

e) Discontinuance and Replacement

If a group ~~traditional~~ long-term care policy is replaced by another group ~~traditional~~ long-term care policy issued to the same policyholder, the succeeding insurer shall offer coverage to all persons covered under the previous group policy on its date of termination. Coverage provided or offered to individuals by the

insurer and premiums charged to persons under the new group policy:

1) Shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced; and

2) Shall not vary or otherwise depend on the individual's health or disability status, claim experience or use of ~~traditional~~ long-term care services.

f) The premiums charged to an insured ~~for traditional long-term care insurance~~ shall not increase due to either:

1) The increasing age of the insured at ages beyond 65; or

2) The duration the insured has been covered under the policy.

g) No ~~traditional~~ long-term care insurance policy shall~~:1)be cancelled, nonrenewed or otherwise terminated on grounds of the age or deterioration of the mental or physical health of the insured individual or certificateholder;2)contain a provision establishing a new waiting period in the event existing coverage is converted to or replaced by new, or other coverage except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder;3)~~provide coverage for skilled nursing care only or provide significantly more coverage for skilled care in a facility than coverage for lower levels of care.

h) Electronic Enrollment for Group Policies

1) In the case of a group defined in Section 351A-1(e) of the Code~~2012.30 of this Part~~, any requirement that a signature of an insured be obtained by an insurance producer or insurer shall be deemed satisfied if:

A) The consent is obtained by telephonic or electronic enrollment by the group policyholder or insurer. A verification of enrollment information shall be provided to the enrollee;

B) The telephonic or electronic enrollment provides necessary and reasonable safeguards to assure the accuracy, retention and prompt retrieval of records; and

C) The telephonic or electronic enrollment provides necessary and

reasonable safeguards to assure that the confidentiality of individually indentifiable information and privileged information is maintained.

2) Upon request of the Director the insurer shall make available records that will demonstrate the insurer's ability to confirm enrollment and coverage amounts.

(Source: Amended at 31 Ill. Reg. _____, effective _____)

Section 2012.55 Unintentional Lapse

Each insurer offering ~~traditional~~ long-term care insurance shall, as a protection against unintentional lapse, comply with the following:

a) Notice before lapse or termination.

1) No individual ~~traditional~~ long-term care policy or certificate shall be issued until the insurer has received from the applicant a written designation of at least one person, in addition to the applicant, who is to receive notice of lapse or termination of the policy or certificate for nonpayment of premium; or a written waiver dated and signed by the applicant electing not to designate additional persons to receive notice. The applicant has the right to designate at least one person who is to receive the notice of termination, in addition to the insured. Designation shall not constitute acceptance of any liability on the third party for services provided to the insured. The form used for the written designation must~~shall~~ provide space clearly designated for listing at least one person. The designation shall include each person's full name and home address. In the case of an applicant who elects not to designate an additional person, the waiver shall state: "Protection against unintended lapse. I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this ~~traditional~~ long-term care insurance policy for nonpayment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid. I elect NOT to designate any person to receive such notice." The insurer shall also notify the insured of the right to change this written designation, no less often then once every 2 years.

2) When the policyholder or certificateholder pays premium for a ~~traditional~~ long-term care insurance policy or certificate through a payroll or pension deduction plan, the requirements contained in subsection (a)(1)~~ above~~ need not be met until 60 days after the policyholder or certificateholder is no longer on such a payment plan. The application or enrollment form for such policies or certificates shall clearly indicate the payment plan selected by the applicant.

3) Lapse or termination for nonpayment of premium. No individual ~~traditional~~ long-term care policy or certificate shall lapse or be terminated for nonpayment of premium unless the insurer, at least 30 days before the effective date of the lapse or termination, has given notice to the insured and to those persons designated pursuant to subsection (a)(1)~~ above~~, at the address provided by the insured for purposes of receiving notice of lapse or termination. Notice shall be given by first class United States mail, postage prepaid; and notice shall not be given until 30 days after a premium is due and unpaid. Notice shall be deemed to have been given as of 5 days after the date of mailing.

b) In addition to the requirements of subsection (a)~~ above~~, a ~~traditional~~ long-term care insurance policy or certificate shall include a provision that~~which~~ provides for reinstatement of coverage, in the event of lapse if the insurer is provided proof that the policyholder or certificateholder was cognitively impaired or had a~~of cognitive impairment, the~~ loss of functional capacity before the grace period contained in the policy expired~~or if the insured would otherwise qualify for benefits under the contract~~. This option shall be available to the insured if requested within 5 months after termination and shall allow for the collection of past due premium when appropriate. The standard of proof of cognitive impairment or loss of functional capacity shall not be more stringent than the benefit eligibility criteria on cognitive impairment or the loss of functional capacity contained in the policy and certificate.

(Source: Amended at 31 Ill. Reg. _____, effective _____)

Section 2012.60 Required Disclosure Provisions

a) Renewability. Individual ~~traditional~~ long-term care insurance policies shall contain a renewability provision. The~~Such~~ provision shall be appropriately captioned~~ as a Renewal~~, shall appear on the first page of the policy, and shall

clearly state that the coverage is guaranteed renewable or noncancellable. This provision shall not apply to policies which do not contain a renewability provision and under which the right to renew is reserved solely to the policyholder. A ~~traditional~~ long-term care insurance policy or certificate, other than one where the insurer does not have the right to change the premium, shall include a statement that premium rates may change.

b) Riders and Endorsements. Except for riders or endorsements by which the insurer effectuates a request made in writing by the insured under an individual ~~traditional~~ long-term care insurance policy, all riders or endorsements added to an individual ~~traditional~~ long-term care insurance policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the individual insured. After the date of policy issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to in writing signed by the insured, except if the increased benefits or coverage are required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, such premium charge shall be set forth in the policy, rider or endorsement.

c) Payment of Benefits. A ~~traditional~~ long-term care insurance policy or certificate that~~which~~ provides for the payment of benefits based on standards described as "usual and customary," "reasonable and customary" or words of similar import shall include a definition of such terms and an explanation of such terms in its accompanying outline of coverage.

d) Limitations~~Preexisting Conditions~~: If a ~~traditional~~ long-term care insurance policy or certificate contains any limitations with respect to preexisting conditions, such limitations shall appear as a separate paragraph of the policy or certificate and shall be labeled "Preexisting Condition Limitations~~.~~". Limitations to preexisting conditions shall be in accordance with Section 351A-5 of the ~~Illinois Insurance~~ Code ~~[215 ILCS 5/351A-5]~~.

e) Other Limitations or Conditions on Eligibility for Benefits. In addition to complying with Section 351A-6 of the ~~Illinois Insurance~~ Code, beginning August 30, 1990, a ~~traditional~~ long-term care insurance policy or certificate containing any limitations or conditions for eligibility other than those prohibited in Section 351A-6 shall set forth a description of such limitations or conditions, including any required number of days of confinement in a separate paragraph of the policy

or certificate and shall label such paragraph "Limitations or Conditions on Eligibility for Benefits~~.~~".

f) Disclosure Requirements for Accelerated Life Products

1) Policy Summary
At the time of policy delivery, a policy summary shall be delivered for an individual life insurance policy that~~which~~ provides ~~traditional~~ long-term care benefits within the policy or by rider. This requirement does not apply to qualified long-term care insurance contracts. In the case of direct response solicitations, the insurer shall deliver the policy summary upon the applicant's request, but regardless of request shall make ~~such~~ delivery no later than at the time of policy delivery. In addition to complying with all applicable requirements, the summary shall also include:

A) an explanation of how the ~~traditional~~ long-term care benefit interacts with other components of the policy, including deductions from death benefits;

B) an illustration of the amount of benefits, the length of benefit, and the guaranteed lifetime benefits if any, for each covered person;

C) any exclusion, reductions and limitations on benefits of ~~traditional~~ long-term care; and

D) if applicable to the policy type, the summary shall also include:

i) disclosure of the effects of exercising other rights under the policy;

ii) disclosure of guarantees related to ~~traditional~~ long-term care costs of insurance charges; and

iii) current and projected maximum lifetime benefits.

2) Benefit Reports
Any time a ~~traditional~~ long-term care benefit, funded through a life insurance vehicle by the acceleration of the death benefit, is in benefit payment status, a monthly report shall be provided to the policyholder.

The~~Such~~ report shall include:

A) any ~~traditional~~ long-term care benefits paid during the month;

B) an explanation of any changes in the policy, including changes in death benefits or cash values, due to ~~traditional~~ long-term care benefits being paid out; and

C) the amount of ~~traditional~~ long-term care benefits existing or remaining.

3) Outline of Coverage
The Outline of Coverage should include an example filled out in John Doe form that~~which~~ illustrates how the ~~traditional~~ long-term care benefit is calculated. Refer to Section 2012.110 and Exhibit C for format and content requirements.

g~~4~~) Disclosure of Tax Consequences. With regard to life insurance policies that provide an accelerated benefit for ~~traditional~~ long-term care, a disclosure statement is required at the time of application for the policy or rider and at the time the accelerated benefit payment request is submitted, that receipt of these accelerated benefits may be taxable, and that assistance should be sought from a personal tax advisor. This disclosure statement shall be prominently displayed on the first page of the policy or rider and any other related documents. This subsection (g)~~(f)(4)~~ shall not apply to qualified long-term care insurance contracts.

h~~g~~) Benefit Triggers. Activities of daily living and cognitive impairment shall be used to measure an insured's need for ~~traditional~~ long-term care and shall be described in the policy or certificate in a separate paragraph and shall be labeled "Eligibility for the Payment of Benefits". Any additional benefit triggers shall also be explained in this paragraph. If these triggers differ for different benefits, explanation of the trigger shall accompany each benefit description. If an attending physician or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, this too shall be specified.

i~~h~~) A qualified long-term care insurance contract shall include a disclosure statement in the policy and in the outline of coverage as contained in ~~Section 2012.~~Exhibit

C(3) of this Part that indicates that the policy is intended to be a qualified long-term care insurance contract under Section 7702B(b)within the meaning of the Internal Revenue Code of 1986, as amended (26 USC 7702B(b)).

j)i) A nonqualified traditional long-term care insurance contract shall include a disclosure statement in the policy and in the outline of coverage as contained in Section 2012.Exhibit C(3) of this Part. The disclosure statement shall indicatethat indicates that the policy is not intended to be a qualified long-term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986, as amended.

(Source: Amended at 31 Ill. Reg. _____, effective _____)

Section 2012.62 Required Disclosure of Rating Practices to Consumers

a) This Section shall apply as follows:

1) Except as provided in subsection (a)(2), this Section applies to any traditional long-term care policy issued in this State on or after January 1, 2003.

2) For certificates issued on or after July 1, 2002, under a group traditional long-term care insurance policy as defined in Section 351A-1(e)(1) of the Code that2012.30, which policy was in force prior to July 1, 2002, the provisions of this Section shall apply on the policy anniversary following July 1, 2003.

b) Other than policies for which no applicable premium rate or rate schedule increases can be made, insurers shall provide all of the information listed in this subsection (b) of this Section to the applicant at the time of application or enrollment, unless the method of application does not allow for delivery at that time. In such a case, an insurer shall provide all of the information listed in this Section to the applicant no later than at the time of delivery of the policy or certificate.

1) A statement that the policy may be subject to rate increases in the future;

2) An explanation of potential future premium rate revisions, and the policyholder's or certificateholder's option in the event of a premium rate

revision;

3) The premium rate or rate schedules applicable to the applicant that will be in effect until a request is made for an increase;

4) A general explanation for applying premium rate or rate schedule adjustments that shall include:

A) A description of when premium rate or rate schedule adjustments will be effective (e.g., next anniversary date, next billing date, etc.); and

B) The right to a revised premium rate or rate schedule as provided in subsection (b)(3)~~(2)~~ of this Section if the premium rate or rate schedule is changed;

5) Required Rate Information

A) Information regarding each premium rate increase on this policy form or similar policy forms over the past 10 years for this State or any other state that, at a minimum, identifies:

i) The policy forms for which premium rates have been increased;

ii) The calendar years when the form was available for purchase; and

iii) The amount or percent of each increase. The percentage may be expressed as a percentage of the premium rate prior to the increase, and may also be expressed as minimum and maximum percentages if the rate increase is variable by rating characteristics.

B) The insurer may, in a fair manner, provide additional explanatory information related to the rate increases.

C) An insurer shall have the right to exclude from the disclosure premium rate increases that only apply to blocks of business

acquired from other nonaffiliated insurers or the ~~traditional~~ long-term care policies acquired from other nonaffiliated insurers when those increases occurred prior to the acquisition.

D) If an acquiring insurer files for a rate increase on a ~~traditional~~ long-term care policy form acquired from nonaffiliated insurers or a block of policy forms acquired from nonaffiliated insurers on or before July 1, 2002, or the end of a 24 month period following the acquisition of the block or policies, the acquiring insurer may exclude that rate increase from the disclosure. However, the nonaffiliated selling company shall include the disclosure of that rate increase in accordance with subsection (b)(5)(A) of this Section.

E) If the acquiring insurer in subsection (b)(5)(D) of this Section files for a subsequent rate increase, even within the 24 month period, on the same policy form acquired from nonaffiliated insurers or block of policy forms acquired from nonaffiliated insurers referenced in subsection (b)(5)(D) of this Section, the acquiring insurer shall make all disclosures required by subsection (b)(5)(A) of this Section, including disclosure of the earlier rate increase referenced in subsection (b)(5)(D) of this Section.

c) An applicant shall sign an acknowledgment at the time of application, unless the method of application does not allow for signature at that time, that the insurer made the disclosure required under subsections (b)(1) and (5) of this Section. If due to the method of application the applicant cannot sign an acknowledgment at the time of application, the applicant shall sign no later than at the time of delivery of the policy or certificate.

d) An insurer shall use Exhibits F and J to comply with the requirements of subsections (b) and (c)~~(a) and (b)~~ of this Section.

e) An insurer shall provide notice of an upcoming premium rate schedule increase to all policyholders or certificateholders, if applicable, at least 45 days prior to the implementation of the premium rate schedule increase by the insurer. The notice shall include the information required by subsection (b) of this Section when the rate increase is implemented.

DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

NOTICE OF PROPOSED AMENDMENTS

(Source: Amended at 31 Ill. Reg. _____, effective _____)

Section 2012.64 Initial Filing Requirements

a) This Section applies to any ~~traditional~~ long-term care policy issued in this State on or after January 1, 2003.

b) An insurer shall provide the information listed in this subsection (b) ~~of this Section~~ to the Director 30 days prior to making a ~~traditional~~ long-term care insurance form available for sale.

1) A copy of the disclosure documents required in Section 2012.62; and

2) An actuarial certification consisting of at least the following:

A) A statement that the initial premium rate schedule is sufficient to cover anticipated costs under moderately adverse experience and that the premium rate schedule is reasonably expected to be sustainable over the life of the form with no future premium increases anticipated;

B) A statement that the policy design and coverage provided have been reviewed and taken into consideration;

C) A statement that the underwriting and claims adjudication processes have been reviewed and taken into consideration;

D) A complete description of the basis for contract reserves that are anticipated to be held under the form, to include:

i) Sufficient detail or sample calculations provided so as to have a complete depiction of the reserve amounts to be held;

ii) A statement that the assumptions used for reserves contain reasonable margins for adverse experience;

iii) A statement that the net valuation premium for renewal years does not increase (except for attained-age rating

where permitted); and

iv) A statement that the difference between the gross premium and the net valuation premium for renewal years is sufficient to cover expected renewal expenses. If such a statement cannot be made, a complete description of the situations where this does not occur must be provided and shall include an aggregate distribution of anticipated issues that may be used as long as the underlying gross premiums maintain a reasonably consistent relationship. In the event that gross premiums for a certain age group appear to be inconsistent with this requirement, the Director may request a demonstration under subsection (c)~~Section 2012.64(c)~~ based on a standard age distribution; and

E) A statement that the premium rate schedule is not less than the premium rate schedule for existing similar policy forms also available from the insurer except for reasonable differences attributable to benefits; or a comparison of the premium schedules for similar policy forms that are currently available from the insurer with an explanation of the differences.

c) The Director may request an actuarial demonstration that benefits are reasonable in relation to premiums. The actuarial demonstration shall include either premium and claim experience on similar policy forms, adjusted for any premium or benefit differences, relevant and credible data from other studies, or both. In the event the Director asks for additional information pursuant to this subsection (c), the 30 day~~January 1, 2003,~~ timeframe identified in subsection~~Section 2012.64~~(b)~~(a)~~ does not include the period during which the insurer is preparing the requested information.

(Source: Amended at 31 Ill. Reg. _____, effective _____)

Section 2012.65 Prohibition Against Post Claims Underwriting

a) All applications for ~~traditional~~ long-term care insurance policies or certificates except those which are guaranteed issue shall contain unambiguous questions designed to ascertain the health condition of the applicant.

1) If an application for ~~traditional~~ long-term care insurance contains a question which asks whether the applicant has had medication prescribed by a physician, it must also ask the applicant to list the medication that has been prescribed.

2) If the medications listed in the~~such~~ application were known by the insurer, or should be known~~were included in the insurers underwriting standards~~ at the time of application, to be directly related to a medical condition for which coverage would otherwise be denied, then the policy or certificate shall not be rescinded for that condition.

b) Except for policies or certificates that~~which~~ are guaranteed issue:

1) The following language shall be set out conspicuously and in close conjunction with~~in bold face type on the same page as~~ the applicant's signature block on an application for a traditional long-term care insurance policy or certificate:

Caution: If your answers on this application are incorrect or untrue, [company] may have the right to deny benefits or rescind your policy.

2) The following language shall be set out on the ~~traditional~~ long-term care insurance policy or certificate at the time of delivery:

Caution: The issuance of this ~~traditional~~ long-term care insurance [policy] [certificate] is based upon your responses to the questions on your application. A copy of your [application] [enrollment form] [is enclosed] [was retained by you when you applied]. If your answers are incorrect or untrue, the company may have the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the company at this address: [insert address]

3) Prior to issuance of a ~~traditional~~ long-term care policy or certificate to an applicant age 80 or older, the insurer shall obtain one of the following:

A) A report of a physical examination;

B) An assessment of functional capacity;

C) An attending physician's statement; or

D) Copies of medical records.

c) A copy of the completed application or enrollment form (whichever is applicable) shall be delivered to the insured no later than at the time of delivery of the policy or certificate unless it was retained by the applicant at the time of application.

d) Every insurer, as defined ~~herein~~, selling or issuing ~~traditional~~ long-term care insurance benefits shall maintain a record of all policy or certificate rescissions, both State and countrywide, except those ~~which~~ the insured voluntarily effectuated and shall annually furnish this information to the Director of Insurance in the format prescribed in Exhibit D.

(Source: Amended at 31 Ill. Reg. _____, effective _____)

Section 2012.70 Minimum Standards for Home Health and Community Care Benefits in ~~Traditional~~ Long-Term Care Insurance Policies

a) A ~~traditional~~ long-term care insurance policy or certificate may not, if it provides benefits for home health care or community care services, limit or exclude benefits:

1) By requiring that the insured/claimant would need skilled care in a skilled nursing facility if home health care services were not provided;

2) By requiring that the insured/claimant first or simultaneously receive nursing and/or therapeutic services in a home or community or institutional setting before home health care services are covered;

3) By limiting eligible services to services provided by registered nurses or licensed practical nurses;

4) By requiring that a nurse or therapist provide services covered by the policy that can be provided by a home health aide, or other licensed or certified home care worker acting within the scope of his or her licensure or certification;

5) By requiring that the insured/claimant have an acute condition before home health care services are covered;

6) By excluding coverage for personal care services provided by a home health aide;

7) By requiring that the provision of home health care services be at a level of certification or licensure greater than that required by the eligible service;

8) By limiting benefits to services provided by Medicare-certified agencies or providers;

9) By excluding coverage for adult day care services.

b) A ~~traditional~~ long-term care insurance policy or certificate, if it provides for home health or community care services, shall provide total home health or community care coverage that is a dollar amount equivalent to at least one-half of one year's coverage available for nursing home benefits under the policy or certificate, at the time covered home health or community care services are being received. This requirement shall not apply to policies or certificates issued to residents of continuing care retirement communities.

c) Home health care coverage may be applied to the nonhome health care benefits provided in the policy or certificate when determining maximum coverage under the terms of the policy or certificate.

(Source: Amended at 31 Ill. Reg. _____, effective _____)

Section 2012.80 Requirement to Offer Inflation Protection

a) No insurer may offer a ~~traditional~~ long-term care insurance policy unless the insurer also offers to the policyholder in addition to any other inflation protection the option to purchase a policy that provides for benefit levels to increase with benefit maximums or reasonable durations which are meaningful to account for reasonably anticipated increases in the costs of ~~traditional~~ long-term care services covered by the policy. Insurers must offer to each policyholder, at the time of purchase, the option to purchase a policy with an inflation protection feature no less favorable than one of the following:

1) Increases benefit levels annually ~~(~~in a manner so that the increases are compounded annually at a rate not less than 5%~~)~~;

2) Guarantees the insured individual the right to periodically increase benefit levels without providing evidence of insurability or health status so long as the option for the previous period has not been declined. The amount of the additional benefit shall be no less than the difference between the existing policy benefit and that benefit compounded annually at a rate of at least 5% for the period beginning with the purchase of the existing benefit and extending until the year in which the offer is made; or

3) Covers a specified percentage of actual or reasonable charges and does not include a maximum specified indemnity amount or limit.

b) Where the policy is issued to a group, the required offer in subsection (a)~~ above~~ shall be made to the group policyholder; except, if the policy is issued to a discretionary group, as defined in Section 351A-1(e)(4) of the Code, other than to a continuing care retirement community, the offering shall be made to each proposed certificateholder.

c) The offer in subsection (a)~~ above~~ shall not be required of life insurance policies or riders containing accelerated ~~traditional~~ long-term care benefits.

d) Insurers shall include the following information in the outline of coverage:

1) A graphic comparison of the benefit levels of a policy that increases benefits over the policy period with a policy that does not increase benefits. The graphic comparison shall show benefit levels over at least a 20 year period.

2) Any expected premium increases or additional premiums to pay for automatic or optional benefit increases. ~~If premium increases or additional premiums will be based on the attained age of the applicant at the time of the increase, the insurer shall also disclose the magnitude of the potential premiums the applicant would need to pay at ages 75 and 85 for benefit increases.~~

3) An insurer may use a reasonable hypothetical or a graphic demonstration

for the purposes of this disclosure.

e) Inflation protection benefit increases under a policy which contains such benefits shall continue without regard to an insured's age, claim status or claim history, or the length of time the person has been insured under the policy.

f) An offer of inflation protection which provides for automatic benefit increases shall include an offer of a premium which the insurer expects to remain constant. The~~Such~~ offer shall disclose in a conspicuous manner~~bold face type~~ that the premium may change in the future unless the premium is guaranteed to remain constant.

g) Inflation protection as provided in subsection (a)(1) of this Section shall be included in a ~~traditional~~ long-term care insurance policy unless an insurer obtains a rejection of inflation protection signed by the policyholder as required by this Section~~hereunder~~. The rejection may be either in the application or on a separate form. The rejection shall be considered a part of the application and shall state, "I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of this policy with and without inflation protection. Specifically, I have reviewed plan(s) _____, and I reject inflation protection."

(Source: Amended at 31 Ill. Reg. _____, effective _____)

Section 2012.83 Incontestability Period

a) For a policy or certificate that has been in force for less than 6 months, an insurer may rescind a long-term care insurance policy or certificate or deny an otherwise valid long-term care insurance claim upon a showing of misrepresentation that is material to the acceptance for coverage.

b) For a policy or certificate that has been in force for at least 6 months but less than 2 years, an insurer may rescind a long-term care insurance policy or certificate or deny an otherwise valid long-term care insurance claim upon a showing of misrepresentation that is both material to the acceptance for coverage and that pertains to the condition for which benefits are sought.

c) After a policy or certificate has been in force for 2 years, it is not contestable upon the grounds of misrepresentation alone; the policy or certificate may be contested

only upon a showing that the insured knowingly and intentionally misrepresented relevant facts relating to the insured's health.

d) A long-term care insurance policy or certificate may be field issued based on medical or health status if the compensation to the field issuer is not based on the number of policies or certificates issued. For purposes of this Section, "field issued" means a policy or certificate issued by a producer or an agent or a third-party administrator pursuant to the underwriting authority granted to the producer, agent or third party administrator by an insurer and using the insurer's underwriting guidelines.

e) If an insurer has paid benefits under the long-term care insurance policy or certificate, the benefit payments may not be recovered by the insurer in the event that the policy or certificate is rescinded.

f) In the event of the death of the insured, this Section shall not apply to the remaining death benefit of a life insurance policy that accelerates benefits for long-term care. In this situation, the remaining death benefits under these policies shall be governed by Section 224(1)(c) of the Code. In all other situations, this Section shall apply to life insurance policies that accelerate benefits for long-term care.

(Source: Added at 31 Ill. Reg. _____, effective _____)

Section 2012.86 Nonforfeiture Benefits

a) Except as provided in subsection (b), a long-term care insurance policy may not be delivered or issued for delivery in this State unless the policyholder or certificateholder has been offered the option of purchasing a policy or certificate including a nonforfeiture benefit as specified in Section 2012.127 of this Part. The offer of a nonforfeiture benefit may be in the form of a rider that is attached to the policy. In the event the policyholder or certificateholder declines the nonforfeiture benefit, the insurer shall provide a contingent benefit upon lapse that shall be available for a specified period of time following a substantial increase in premium rates.

b) When a group long-term care insurance policy is issued, the offer required in subsection (a) shall be made to the group policyholder. However, if the policy is issued as group long-term care insurance as defined in Section 351A-1(e)(4) of

the Code, other than to a continuing care retirement community or other similar entity, the offering shall be made to each proposed certificateholder.

(Source: Added at 31 Ill. Reg. _____, effective _____)

Section 2012.90 Requirements for Application Forms and Replacement Coverage

a) Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant has another ~~traditional~~ long-term care insurance policy or certificate in force or whether a ~~traditional~~ long-term care policy or certificate is intended to replace any other accident and sickness or ~~traditional~~ long-term care policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and insurance producer, except where the coverage is sold without an insurance producer, containing such questions may be used. With regard to a replacement policy issued to a group defined by Section 351A-1(e)(1) of the Code~~Section 2012.30 of this Part~~ the following questions may be modified only to the extent necessary to elicit information about health or ~~traditional~~ long-term care insurance policies other than the group policy being replaced; provided, however, that the certificateholder has been notified of the replacement.

1) Do you have another ~~traditional~~ long-term care insurance policy or certificate in force (including health care service contract, health maintenance organization contract)?

2) Did you have another ~~traditional~~ long-term care insurance policy or certificate in force during the last 12 months?

A) If so, with which company?

B) If that policy lapsed, when did it lapse?

3) Are you covered by Medicaid?

4) Do you intend to replace any of your medical or health insurance coverage with this policy (certificate)?

b) Insurance producers shall list any other health insurance policies they have sold to the applicant.

1) List policies sold which are still in force.

2) List policies sold in the past 5 years which are no longer in force.

c) Solicitations Other than Direct Response. Upon determining that a sale will involve replacement, an insurer, other than an insurer using direct response solicitation methods, or its insurance producer, shall furnish the applicant, prior to issuance or delivery of the individual ~~traditional~~ long-term care insurance policy, a notice regarding replacement of accident and sickness or ~~traditional~~ long-term care coverage. One copy of such notice shall be retained by the applicant and an additional copy signed by the applicant shall be retained by the insurer. The required notice shall be provided as set forth in Exhibit A of this Part.

d) Direct Response Solicitations. Insurers using direct response solicitation methods shall deliver a notice regarding replacement of accident and sickness or ~~traditional~~ long-term care coverage to the applicant upon issuance of the policy. The required notice shall be provided as set forth in Exhibit B of this Part.

e) Where replacement is intended, the replacing insurer shall provide written notice to the existing insurer of the proposed replacement. The existing policy shall be identified by the insurer, name of insured and policy number or address including zip code. Notice shall be made within 5 working days from the date the application is received by the insurer or the date the policy issued, whichever is sooner.

(Source: Amended at 31 Ill. Reg. _____, effective _____)

Section 2012.95 Reporting Requirements

All insurers shall:

a) Maintain records for each insurance producer of that producer's amount of replacement sales as a percent of the producer's total annual sales and the amount of lapses of ~~traditional~~ long-term care insurance policies sold by the insurance producer as a percent of the producer's total ~~renewing~~ sales. ~~Total renewing sales means policies in force at the end of the calendar year prior to the year of lapse.~~

b) Report annually by June 30 the 10% of its insurance producers with the greatest

percentages of lapses and replacements as measured by subsection (a)~~ above~~ as provided in Exhibit K of this Part.~~ The reports shall include lapses and replacements that occur in the most recent calendar year ending December 31. Only insurance producers with at least 10 total renewing sales, or 5 new sales in the report period shall be included in the lapse report.~~

c) Report annually by June 30 the number of lapsed policies as a percent of its total annual sales and as a percent of its total number of policies in force as of the end of the preceding calendar year as provided in Exhibit K of this Part.

d) Report annually by June 30 the number of replacement policies sold as a percent of its total annual sales and as a percent of its total number of policies in force as of the preceding calendar year as provided in Exhibit K of this Part.

e) Report~~Every insurer shall report~~ annually by June 30, for qualified long-term care insurance contracts, the number of claims denied for each class of business, expressed as a percentage of claims denied, as provided by~~. Please see~~ Exhibit I of this Part.

f) For purposes of this Section:

1) "Policy" means only ~~traditional~~ long-term care insurance;

2) Subject to subsection (f)(3) of this Section, "claim" means a request for payment of benefits under an in force policy regardless of whether the benefit claimed is covered under the policy or any terms or conditions of the policy have been met;

3) "Denied" means the insurer refuses to pay a claim for any reason other than for claims not paid for failure to meet the waiting period or because of an applicable preexisting condition; and

4) "Report" means on a Statewide basis.

g) Reports required under this Section shall be filed with the Director.

(Source: Amended at 31 Ill. Reg. _____, effective _____)

Section 2012.100 Filing Requirement

DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

NOTICE OF PROPOSED AMENDMENTS

Prior to an insurer offering ~~traditional~~ group ~~traditional~~ long-term care insurance to a resident of this State pursuant to Section 351A-2 of the ~~Illinois Insurance~~ Code ~~[215 ILCS 5/351A-2]~~, it shall file with the Director evidence that the group policy or certificate thereunder has been approved by a state that has adopted the National Association of Insurance Commissioners' model legislation on Long-Term Care Insurance and attendant regulations, 2301 McGee Street, Suite 800, Kansas City, Missouri 64108 (2000) (no subsequent dates or editions).

(Source: Amended at 31 Ill. Reg. _____, effective _____)

Section 2012.110 Loss Ratio

a) This Section shall apply to all ~~traditional~~ long-term care insurance policies or certificates, except those covered under Sections 2012.64 and 2012.112.

b) Benefits under ~~traditional~~ long-term care insurance policies shall be deemed reasonable in relation to premiums if~~provided~~ the expected~~lifetime anticipated~~ loss ratio is at least 60%, calculated in a manner that provides for adequate reserving of the long-term care insurance~~on the basis of the ratio of the present value of the expected benefits to the present value of the expected premiums over the entire period for which rates are computed to provide coverage~~. In evaluating the expected~~lifetime anticipated~~ loss ratio, due consideration shall be given to all relevant factors, including~~the following factors~~:

1) Statistical credibility of incurred claims experience and earned premiums;~~based on the following factors: claim rates, variability in transaction costs, and number of lives exposed.~~

2) The period for which rates are computed to provide coverage;

3) Experienced~~Experience~~ and projected trends;

4) Concentration of experience within early policy duration;

5) Expected claim fluctuation;

6) Experience refunds, adjustments or dividends;

7) Renewability features;

8) Interest;

9) Experimental nature of the coverage;

10) Product features such as long elimination periods (period between when the claim arises and insured is eligible to receive benefits), high deductibles and high maximum limits.

c) Subsection (b) of this Section shall not apply to life insurance policies that accelerate benefits for ~~traditional~~ long-term care. A life insurance policy that funds ~~traditional~~ long-term care benefits entirely by accelerating the death benefit is considered to provide reasonable benefits in relation to premiums paid, if the policy complies with all of the following provisions:

1) The interest credited internally to determine cash value accumulations, including ~~traditional~~ long-term care, if any, is guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without ~~traditional~~ long-term care set forth in the policy;

2) The portion of the policy that provides life insurance benefits meets the nonforfeiture requirements of Section 229.2 of the ~~Illinois Insurance~~ Code ~~[215 ILCS 5/229.2]~~;

3) The policy meets the disclosure requirements of Sections ~~Section~~ 351A-9.1 and 351A-9.2 of the Code ~~2012.60~~;

4) Any policy illustration that meets the applicable requirements of 50 Ill. Adm. Code 1406;

5) An actuarial memorandum is filed with the Department that includes:

A) A description of the basis on which the ~~traditional~~ long-term care rates were determined;

B) A description of the basis for the reserves;

C) A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;

D) A description and a table of each actuarial assumption used. For expenses, an insurer must include percent of premium dollars per policy and dollars per unit of benefits, if any;

E) A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;

F) The estimated average annual premium per policy and the average issue age;

G) A statement as to whether underwriting is performed at the time of application. The statement shall indicate whether underwriting is used and, if used, the statement shall include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and

H) A description of the effect of the ~~traditional~~ long-term care policy provision on the required premiums, nonforfeiture values and reserves on the underlying life insurance policy, both for active lives and those in ~~traditional~~ long-term care claim status.

(Source: Amended at 31 Ill. Reg. _____, effective _____)

Section 2012.112 Premium Rate Schedule Increases

a) This Section shall apply as follows:

1) Except as provided in subsection (a)(2) of this Section, this Section applies to any ~~traditional~~ long-term care policy issued in this State on or after January 1, 2003.

2) For certificates issued on or after July 1, 2002, under a group ~~traditional~~ long-term care insurance policy as defined in Section 351A-1(e)(1) of the Code~~2012.30~~, if the~~which~~ policy was in force prior to July 1, 2002, the provisions of this Section shall apply on the policy anniversary following July 1, 2003.

b) An insurer shall provide notice of a pending premium rate schedule increase, including an exceptional increase, to the Director at least 30 days prior to the notice to the policyholders and shall include:

1) Information required by Section 2012.62;

2) Certification by a qualified actuary that:

A) If the requested premium rate schedule increase is implemented and the underlying assumptions that reflect moderately adverse conditions are realized, no further premium rate schedule increases are anticipated;

B) The premium rate filing is in compliance with the provisions of this Section;

3) An actuarial memorandum justifying the rate schedule change request that includes:

A) Lifetime projections of earned premiums and incurred claims based on the filed premium rate schedule increase; and the method and assumptions used in determining the projected values, including reflection of any assumptions that deviate from those used for pricing other forms currently available for sale;

i) Annual values for the 5 years preceding and the 3 years following the valuation date shall be provided separately;

ii) The projections shall include the development of the lifetime loss ratio, unless the rate increase is an exceptional increase;

iii) The projections shall demonstrate compliance with subsection (c) of this Section; and

iv) For exceptional increases, the projected experience should be limited to the increases in claims expenses attributable to the approved reasons for the exceptional increase; and in

the event the Director determines, as provided in the definition of "Exceptional Increase" found in Section 2012.30, that offsets may exist, the insurer shall use appropriate net projected experience;

B) Disclosure of how reserves have been incorporated in this rate increase whenever the rate increase will trigger the contingent benefit upon lapse;

C) Disclosure of the analysis performed to determine why a rate adjustment is necessary, which pricing assumptions were not realized and why, and what other actions taken by the company have been relied on by the actuary;

D) A statement that policy design, underwriting and claims adjudication practices have been taken into consideration; and

E) In the event that it is necessary to maintain consistent premium rates for new certificates and certificates receiving a rate increase, the insurer will need to file composite rates reflecting projections of new certificates;

4) A statement that renewal premium rate schedules are not greater than new business premium rate schedules except for differences attributable to benefits, unless sufficient justification is provided to the Director; and

5) Sufficient information for review by the Director of the premium rate schedule increase.

c) All premium rate schedule increases shall be determined in accordance with the following requirements:

1) Exceptional increases shall provide that 70% of the present value of projected additional premiums from the exceptional increase will be returned to policyholders in benefits;

2) Premium rate schedule increases shall be calculated such that the sum of the accumulated value of incurred claims, without the inclusion of active life reserves, and the present value of future projected incurred claims,

without the inclusion of active life reserves, will not be less than the sum of the following:

A) The accumulated value of the initial earned premium times 58%;

B) 85% of the accumulated value of prior premium rate schedule increases on an earned basis;

C) The present value of future projected initial earned premiums times 58%; and

D) 85% of the present value of future projected premiums not in subsection (c)(2)(C) of this Section on an earned basis;

3) In the event that a policy form has both exceptional and other increases, the values in subsections (c)(2)(B) and (D) of this Section will also include 70% for exceptional rate increase amounts; and

4) All present and accumulated values used to determine rate increases shall use the maximum valuation interest rate for contract reserves as specified in 50 Ill. Adm. Code 2004~~.20(c)~~ (Accident and Health Reserves). The actuary shall disclose as part of the actuarial memorandum the use of any appropriate averages.

d) For each rate increase that is implemented, the insurer shall file for review by the Director updated projections, as defined in subsection (b)(3)(A) of this Section, annually for the next 3 years and include a comparison of actual results to projected values. The Director may extend the period to greater than 3 years if actual results are not consistent with projected values from prior projections. For group insurance policies that meet the conditions in subsection (k) of this Section, the projections required by this subsection (d) shall be provided to the policyholder in lieu of filing with the Director.

e) If any premium rate in the revised premium rate schedule is greater than 200% of the comparable rate in the initial premium schedule, lifetime projections, as defined in subsection (b)(3)(A) of this Section, shall be filed for review by the Director every 5 years following the end of the required period in subsection (d) of this Section. For group insurance policies that meet the conditions in subsection (k) of this Section, the projections required by this subsection (e) shall

be provided to the policyholder in lieu of filing with the Director.

f) If the Director has determined that the actual experience following a rate increase does not adequately match the projected experience and that the current projections under moderately adverse conditions demonstrate that incurred claims will not exceed proportions of premiums specified in subsection (c) of this Section, the Director:

1) May require the insurer to implement any of the following:

A) Premium rate schedule adjustments; or

B) Other measures to reduce the difference between the projected and actual experience.

2) Should give consideration to subsection (b)(3)(E) of this Section when determining whether the actual experience adequately matches the projected experience.

g) If the majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse, the insurer shall file:

1) A plan, subject to the Director's approval, for improved administration or claims processing designed to eliminate the potential for further deterioration of the policy form requiring further premium rate schedule increases, or both, or to demonstrate that appropriate administration and claims processing have been implemented or are in effect; otherwise the Director may impose the condition in subsection (h) of this Section; and

2) The original anticipated lifetime loss ratio, and the premium rate schedule increase that would have been calculated according to subsection (c) of this Section had the greater of the original anticipated lifetime loss ratio or 58% been used in the calculations described in subsections (c)(2)~~(1)~~(A) and (c)(2)(C) of this Section.

h) The Director shall review, for all policies included in the filing, the projected lapse rates and past lapse rates during the 12 months following each increase to determine if significant adverse lapsation has occurred or is anticipated:

1) For a rate increase filing that meets the following criteria:

A) The rate increase is not the first rate increase requested for the specific policy form or forms;

B) The rate increase is not an exceptional increase; and

C) The majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse.

2) In the event significant adverse lapsation has occurred, is anticipated in the filing or is evidenced in the actual results as presented in the updated projections provided by the insurer following the requested rate increase, the Director may determine that a rate spiral exists. Following the determination that a rate spiral exists, the Director may require the insurer to offer, without underwriting, to all in force insureds subject to the rate increase the option to replace existing coverage with one or more reasonably comparable products being offered by the insurer or its affiliates.

A) The offer shall:

i) Be subject to the approval of the Director;

ii) Be based on actuarially sound principles, but not be based on attained age; and

iii) Provide that maximum benefits under any new policy accepted by an insured shall be reduced by comparable benefits already paid under the existing policy.

B) The insurer shall maintain the experience of all the replacement insureds separate from the experience of insureds originally issued the policy forms. In the event of a request for a rate increase on the policy form, the rate increase shall be limited to the lesser of:

i) The maximum rate increase determined based on the combined experience; and

ii) The maximum rate increase determined based only on the experience of the insured's originally issued form plus 10%.

i) If the Director determines that the insurer has exhibited a persistent practice of filing inadequate initial premium rates for ~~traditional~~ long-term care insurance, the Director may, in addition to the provisions of subsection (h) of this Section, prohibit the insurer from either of the following:

1) Filing and marketing comparable coverage for a period of up to 5 years; or

2) Offering all other similar coverages and limiting marketing of new applications to the products subject to recent premium rate schedule increases.

j) Subsections (a) through (i) of this Section shall not apply to policies for which the ~~traditional~~ long-term care benefits provided by the policy are "Incidental", as defined in Section 2012.30, if the policy complies with all of the following provisions:

1) The interest credited internally to determine cash value accumulations, including ~~traditional~~ long-term care, if any, is guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without ~~traditional~~ long-term care set forth in the policy;

2) The portion of the policy that provides insurance benefits other than ~~traditional~~ long-term care coverage meets the nonforfeiture requirements as applicable in any of the following:

A) Section 229.2 of the ~~Illinois Insurance~~ Code [215 ILCS 5/229.2];

B) Section 229.4 of the ~~Illinois Insurance~~ Code [215 ILCS 5/229.4];

3) The policy meets the disclosure requirements of Sections 351A-9.1 and 9.2 of the Code~~2012.60, 2012.62 and 2012.64~~;

4) The portion of the policy that provides insurance benefits other than ~~traditional~~ long-term care coverage meets the requirements as applicable in the following:

A) Policy illustrations as required by 50 Ill. Adm. Code 1406;

B) Disclosure requirements in 50 Ill. Adm. Code 1451;

5) An actuarial memorandum is filed with the Director that includes:

A) A description of the basis on which the ~~traditional~~ long-term care rates were determined;

B) A description of the basis for the reserves;

C) A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;

D) A description and a table of each actuarial assumption used. For expenses, an insurer must include percent of premium dollars per policy and dollars per unit of benefits, if any;

E) A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;

F) The estimated average annual premium per policy and the average issue age;

G) A statement as to whether underwriting is performed at the time of application. The statement shall indicate whether underwriting is used and, if used, the statement shall include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and

H) A description of the effect of the ~~traditional~~ long-term care policy provision on the required premiums, nonforfeiture values and reserves on the underlying insurance policy, both for active lives and those in ~~traditional~~ long-term care claim status.

k) Subsections (f) and (h) of this Section shall not apply to group insurance policies as defined in Section 351A-1(e)(1) of the Code if~~2012.30 where~~:

1) The policies insure 250 or more persons and the policyholder has 5,000 or more eligible employees of a single employer; or

2) The policyholder, and not the certificateholders, pays a material portion of the premium, which shall not be less than 20% of the total premium for the group in the calendar year prior to the year a rate increase is filed.

(Source: Amended at 31 Ill. Reg. _____, effective _____)

Section 2012.115 Filing Requirements for Advertising

Every insurer, as defined herein, providing ~~traditional~~ long-term care insurance or benefits in this State shall comply with 50 Ill. Adm. Code 2002.180.

(Source: Amended at 31 Ill. Reg. _____, effective _____)

Section 2012.120 Reserve Standards

a) When ~~traditional~~ long-term care benefits are provided through the acceleration of benefits under group or~~and~~ individual life policies or riders to such policies, policy reserves for such benefits shall be determined in accordance with Section 223 of the ~~Illinois Insurance~~ Code ~~[215 ILCS 5/223]~~. Claim reserves must also be established ~~in the case~~ when the~~such~~ policy or rider is in claim status (see 50 Ill. Adm. Code 2004.40). Reserves for policies and riders subject to this subsection should be based on the multiple decrement model utilizing all relevant decrements except for voluntary termination rates. Single decrement approximations are acceptable if the calculation produces reserves which differ from the reserves based on the multiple decrement approach by less than 5% for each combination of issue age and duration, or are greater than the reserves based on the multiple decrement approach, or if the reserves for this line of business are less than 5% of the statutory net worth of the company. The calculations may take into account the reduction in life insurance benefits due to the payment of ~~traditional~~ long-term care benefits. However, in no event shall the reserves for the ~~traditional~~ long-term care benefit and life insurance benefit be less than the reserves for the life insurance benefit assuming no ~~traditional~~ long-term care benefit. In the development and calculation of reserves for policies and riders subject to this subsection, due regard shall be given to the applicable policy provisions, marketing methods, administrative procedures and all other considerations which

have an impact on projected claim costs, including, but not limited to, the following:

1) Definition of insured events

2) Covered ~~traditional~~ long-term care facilities

3) Existence of home convalescence care coverage

4) Definition of facilities

5) Existence or absence of barriers to eligibility

6) Premium waiver provision

7) Renewability

8) Ability to raise premiums

9) Marketing method

10) Underwriting procedures

11) Claims adjustment procedures

12) Waiting period

13) Maximum benefit

14) Availability of eligible facilities

15) Margins in claim costs

16) Optional nature of benefit

17) Delay in eligibility for benefit

18) Inflation protection provisions

19) Guaranteed insurability option

b) The valuation morbidity table shall be accompanied by a statement declaring it as appropriate as a statutory valuation table by a member of the American Academy of Actuaries.

c) When ~~traditional~~ long-term care benefits are provided other than as in subsection (a)~~ above~~, reserves shall be determined in accordance with Section 353a of the ~~Illinois Insurance~~ Code~~ [215 ILCS 5/353a]~~.

(Source: Amended at 31 Ill. Reg. _____, effective _____)

Section 2012.121 Producer Training Requirements

a) Long-Term Care Training Required

1) An individual may not sell, solicit or negotiate long-term care insurance unless the individual is licensed as an insurance producer for accident and health and has completed a one-time training course. The training shall meet the requirements set forth in subsection (b).

2) An individual already licensed and selling, soliciting or negotiating long-term care insurance on July 1, 2008 may not continue to sell, solicit or negotiate long term care insurance unless the individual has completed a one-time training course, as set forth in subsection (b), within one year from July 1, 2008.

3) In addition to the one-time training course required in subsection (a)(1) and (2), an individual who sells, solicits or negotiates long-term care insurance shall complete ongoing training as set forth in subsection (b).

4) The training requirements of subsection (b) may be approved as continuing education courses under Section 500-35(b)(1) of the Code.

b) Minimum Education and Training Requirements

1) The one-time training required by this Section shall be no less than 8 hours and the ongoing training required by this Section shall be no less than 4 hours in 24 months.

2) The training required under subsection (b)(1) shall consist of topics related to long-term care insurance, long-term care services and, if applicable, qualified state long-term care insurance Partnership programs, including, but not limited to:

A) State and federal regulations and requirements and the relationship between qualified state long-term care insurance Partnership programs and other public and private coverage of long-term care services, including Medicaid;

B) Available long-term care services and providers;

C) Changes or improvements in long-term care services or providers;

D) Alternatives to the purchase of private long-term care insurance;

E) The effect of inflation on benefits and the importance of inflation protection; and

F) Consumer suitability standards and guidelines.

3) The training required by this Section shall not include training that is insurer or company product specific or that includes any sales or marketing information, materials, or training, other than those required by State or federal law.

c) Verification of Training

1) Insurers subject to this Part shall obtain verification that a producer receives training required by subsection (a) of this Section before a producer is permitted to sell, solicit or negotiate the insurer's long-term care insurance products, maintain records subject to the state's record retention requirements, and make that verification available to the Director upon request.

2) Insurers subject to this Part shall maintain records with respect to the training of their producers concerning the distribution of their Partnership policies that will allow the state insurance department to provide assurance

to the state Medicaid agency that producers have received the training contained in subsection (b)(2)(A) as required by subsection (a) and that producers have demonstrated an understanding of the Partnership policies and their relationship to public and private coverage of long-term care, including Medicaid, in this State. These records shall be maintained in accordance with the state's record retention requirements and shall be made available to the Director upon request.

d) The satisfaction of these training requirements in any state shall be deemed to satisfy the training requirements in this State.

(Source: Added at 31 Ill. Reg. _____, effective _____)

Section 2012.122 Standards for Marketing

a) Every insurer, as defined herein, marketing ~~traditional~~ long-term care insurance coverage in this State, directly or through its producers, shall:

1) Establish marketing procedures and producer training requirements to assure that: ~~any comparison of policies by its producers will be accurate.~~

A) Any marketing activities, including any comparison of policies, by its agents or other producers will be fair and accurate; and

B) Excessive ~~Establish marketing procedures to assure that excessive~~ insurance is not sold or issued.

2) Display prominently by type or stamp or other appropriate means on the first page of the outline of coverage and policy the following: "NOTICE TO BUYER: THIS POLICY MAY NOT COVER ALL THE COSTS ASSOCIATED WITH LONG-TERM CARE INCURRED BY THE BUYER DURING THE PERIOD OF COVERAGE. THE BUYER IS ADVISED TO REVIEW CAREFULLY ALL POLICY LIMITATIONS."

3) Provide copies of the disclosure forms required in Section 2012.62(c) and Exhibits F and J of this Part ~~I~~ to the applicant.

4) Inquire of a prospective applicant or enrollee for ~~traditional~~ long-term care insurance, and otherwise make every reasonable effort to identify, whether

the applicant or enrollee~~they~~ already has~~have~~ accident and sickness or ~~traditional~~ long-term care insurance and the types and amounts of any such insurance, except that, in the case of qualified ~~traditional~~ long-term care insurance contracts, an inquiry into whether a prospective applicant or enrollee for long-term care insurance has accident and sickness insurance is not required.

5) Every insurer or entity marketing ~~traditional~~ long-term care insurance shall establish auditable procedures for verifying compliance with this subsection.

6) The insurer shall, at solicitation, provide written notice to the prospective policyholder and certificateholder of the Senior Health Insurance Program (SHIP) that such a program is available and the most current name, address and telephone number of the program. The current address and toll-free telephone number is 320 W. Washington Street, Springfield, Illinois 62767-0001, 1-800-548-9034.

7) For ~~traditional~~ long-term care health insurance policies and certificates, use the terms "noncancellable" or "level premium" only when the policy or certificate conforms to Section 2012.50(a)(3) of this Part.

8) ~~Traditional long-term care insurance policies or certificates sold after July 1, 1995 that are not under the Illinois Long-Term Care Partnership Program shall include a statement on the outline of coverage, the policy or certificate application, and the front page of the policy or certificate in bold type and in a separate box as follows: "THIS POLICY (CERTIFICATE) IS NOT APPROVED FOR MEDICAID ASSET PROTECTION UNDER THE ILLINOIS LONG-TERM CARE PARTNERSHIP PROGRAM. HOWEVER, THIS POLICY (CERTIFICATE) IS AN APPROVED TRADITIONAL LONG-TERM CARE POLICY (CERTIFICATE) UNDER STATE INSURANCE REGULATIONS. FOR INFORMATION ABOUT POLICIES AND CERTIFICATES APPROVED UNDER THE ILLINOIS TRADITIONAL LONG-TERM CARE PARTNERSHIP PROGRAM, CALL THE SENIOR HELPLINE AT THE DEPARTMENT ON AGING AT 1-800-252-8966."9)~~Provide an explanation of the contingent benefit upon lapse provided for in Section 2012.127(d)(2) of this Part and, if applicable, the additional contingent benefit upon lapse provided to policies with fixed or

limited premium paying periods in Section 2012.127(d)(3) of this Part.

b) In addition to the practices prohibited in Article XXVI of the Code, ~~[215 ILCS 5/Art. XXVI et seq.],~~the following acts and practices are prohibited:

1) Twisting. Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on or convert any insurance policy or to take out a policy of insurance with another insurer.

2) High pressure tactics. Employing any method of marketing having the effect of, or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.

3) Cold lead advertising. Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance producer or insurance company.

4) Misrepresentation. Misrepresenting a material fact in selling or offering to sell a ~~traditional~~ long-term care insurance policy.

c) With respect to the obligations set forth in this subsection, the primary responsibility of an association when endorsing or procuring ~~traditional~~ long-term care insurance shall be to educate its members concerning ~~traditional~~ long-term care issues in general so that its members can make informed decisions. Associations should provide information regarding ~~traditional~~ long-term care insurance policies or certificates to ensure that members of such associations receive a balanced and complete explanation of the features in the policies or certificates that are being sold by the insurer.

1) The insurer shall file with this Department the following material:

A) The policy and certificate,

B) A corresponding outline of coverage, as referenced in ~~Section~~

~~2012.130 and~~ Exhibit C of this Part, and

C) All advertisements requested by the Department.

2) The association shall disclose in any ~~traditional~~ long-term care insurance solicitation:

A) The specific nature and amount of the compensation arrangements (including all fees, commissions, administrative fees and other forms of financial support) that the association receives from the endorsement or sale of the policy or certificate to its members, and

B) A brief description of the processes under which such policies and the insurer issuing such policies were selected.

3) If the association and the insurer have interlocking directorates or trustee arrangements, the association shall disclose such fact to its members.

4) The board of directors of associations shall review and approve such insurance policies as well as the compensation arrangements made with the insurer.

5) Except with respect to qualified long-term care insurance contracts, the~~The~~ association shall also:

A) Engage~~engage~~ the services of a person with expertise in ~~traditional~~ long-term care insurance, not affiliated with the insurer, to conduct an examination of the policies including its benefits, features, and rates and update such examination thereafter in the event of a material change;~~.~~

B) Actively monitor the marketing efforts of the insurer and its agents; and

C) Review and approve all marketing materials or other insurance communications used to promote sales or sent to members regarding the policies or certificates.

6) No group ~~traditional~~ long-term care insurance policy or certificate may be

issued to an association unless the insurer files with this Department the information required in this subsection (c).

7) The insurer shall not issue a ~~traditional~~ long-term care policy or certificate to an association or continue to market such a policy or certificate unless the insurer certifies annually that the association has complied with the requirements set forth in this subsection (c).

~~d) The insurer shall provide producer training as follows:~~

~~1) The insurer shall provide written evidence to the Department of Insurance that procedures are in place to assure that no producer will be authorized to market, sell, solicit, or otherwise contact any person for the purpose of marketing a traditional long-term care policy or certificate unless the producer has completed 6 hours of training on traditional long-term care insurance as prescribed in Exhibit E of this Part; the course shall be specifically titled "Traditional Long-Term Care Insurance Policy." The traditional long-term care course cannot be included as part of any other certified continuing education course; however, this course may satisfy a part of the continuing education requirements of Section 494.1(c) of the Illinois Insurance Code [215 ILCS 5/491.1(c)]. Insurers and producers shall maintain evidence of completion of the hours of training required and shall provide proof of completion upon request. Such proofs of completion shall be in the format prescribed by 50 Ill. Adm. Code 3119.Exhibit D, and shall be signed by the producer and the provider of the education attesting to the completion of the required training.~~

~~2) The required training hours referenced in subsection 2012.122(d)(1) above may qualify as part of the continuing education requirements of Section 494.1(c) of the Illinois Insurance Code [215 ILCS 5/494.1(c)] only if the training course has been certified under 50 Ill. Adm. Code 3119.30. Each educational provider shall submit its request for certification to the Director on a form prescribed by 50 Ill. Adm. Code 3119.Exhibit B at least 30 days prior to any course being offered. All educational providers and training courses qualifying for continuing education credit shall be renewed on an annual basis.~~

(Source: Amended at 31 Ill. Reg. _____, effective _____)

DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

NOTICE OF PROPOSED AMENDMENTS

Section 2012.123 Suitability

a) This Section shall not apply to life insurance policies that accelerate benefits for ~~traditional~~ long-term care.

b) Every insurer, health care service plan or other entity marketing ~~traditional~~ long-term care insurance (the "issuer") shall:

1) Develop and use suitability standards to determine whether the purchase or replacement of ~~traditional~~ long-term care insurance is appropriate for the needs of the applicant;

2) Train its insurance producers in the use of its suitability standards; and

3) Maintain a copy of its suitability standards and make them available for inspection upon request by the Director.

c) To determine whether the applicant meets the standards developed by the issuer:

1) The insurance producer and issuer shall develop procedures that take the following into consideration:

A) The ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage;

B) The applicant's goals or needs with respect to ~~traditional~~ long-term care and the advantages and disadvantages of insurance to meet these goals or needs; and

C) The values, benefits and costs of the applicant's existing insurance, if any, when compared to the values, benefits and costs of the recommended purchase or replacement.

2) The issuer, and where an insurance producer is involved, the insurance producer shall make reasonable efforts to obtain the information referenced in subsection (c)(1) of this Section. The efforts shall include presentation to the applicant, at or prior to application, of the "~~Traditional~~ Long-Term Care Insurance Personal Worksheet". The personal worksheet used by the issuer shall contain, at a minimum, the information in the

format contained in Exhibit F of this Part, in not less than 12 point type. The issuer may request the applicant to provide additional information to comply with its suitability standards. A copy of the issuer's personal worksheet shall be filed with the Director.

3) A completed personal worksheet shall be returned to the issuer prior to the issuer's consideration of the applicant for coverage, except the personal worksheet need not be returned for sales of employer ~~traditional~~ group ~~traditional~~ long-term care insurance to employees and their spouses.

4) The sale or dissemination outside the company or agency by the issuer or insurance producer of information obtained through the personal worksheet in Exhibit F of this Part is prohibited.

d) The issuer shall use the suitability standards it has developed pursuant to this Section in determining whether issuing ~~traditional~~ long-term care insurance coverage to an applicant is appropriate.

e) Insurance producers shall use the suitability standards developed by the issuer in marketing ~~traditional~~ long-term care insurance.

f) At the same time as the personal worksheet is provided to the applicant, the disclosure form entitled "Things You Should Know Before You Buy ~~Traditional~~ Long-Term Care Insurance" shall be provided. The form shall be in the format found in Exhibit G of this Part, in not less than 12 point type.

g) If the issuer determines that the applicant does not meet its financial suitability standards, or if the applicant has declined to provide the information, the issuer may reject the application. In the alternative, the issuer shall send the applicant a suitability letter similar to the one found in Exhibit H of this Part. However, if the applicant has declined to provide financial information, the issuer may use some other method to verify the applicant's intent. Either the applicant's returned letter or a record of the alternative method of verification shall be made part of the applicant's file.

h) The issuer shall report annually to the Director the total number of applications received from residents of this State, the number of those who declined to provide information on the personal worksheet, the number of applicants who did not meet the suitability standards, and the number of those who chose to confirm after

receiving a suitability letter.

(Source: Amended at 31 Ill. Reg. _____, effective _____)

Section 2012.124~~126~~ Prohibition Against Preexisting Conditions and Probationary Periods in Replacement Policies or Certificates

If a ~~traditional~~ long-term care insurance policy or certificate replaces another ~~traditional~~ long-term care policy or certificate, the replacing insurer shall waive any time periods applicable to preexisting conditions and probationary periods in the new ~~traditional~~ long-term care policy for similar benefits to the extent that similar exclusions have been satisfied under the original policy.

(Source: Section 2012.126 renumbered to Section 2012.124 and amended at 31 Ill. Reg. _____, effective _____)

Section 2012.125 Availability of New Services or Providers

a) An insurer shall notify policyholders of the availability of a new long-term care policy series that provides coverage for new long-term care services or providers that are material in nature and not previously available through the insurer to the general public. The notice shall be provided within 12 months after the date the new policy series is made available for sale in this State. New long-term care services or providers that are material in nature shall not include changes to policy structure or benefits or provisions that are minor in nature. Examples of when notification need not be provided include changes in elimination periods, benefit periods and benefit amounts.

b) Notwithstanding subsection (a), notification is not required for any policy issued prior to July 2007, or to any policyholder or certificateholder who is currently eligible for benefits, within an elimination period or on claim, or who previously has been in claim status, or who would not be eligible to apply for coverage due to issue age limitations under the new policy. The insurer may require that policyholders meet all eligibility requirements, including underwriting and payment of the required premium to add new services or providers.

c) The insurer shall make the new coverage available in one of the following ways:

1) By adding a rider to the existing policy and charging a separate premium for the new rider based on the insured's attained age;

2) By exchanging the existing policy or certificate for one with an issue age based on the present age of the insured and recognizing past insured status by granting premium credits toward the premiums for the new policy or certificate. The premium credits shall be based on premiums paid or reserves held for the prior policy or certificate;

3) By exchanging the existing policy or certificate for a new policy or certificate in which consideration for past insured status shall be recognized by setting the premium for the new policy or certificate at the issue age of the policy or certificate being exchanged. The cost for the new policy or certificate may recognize the difference in reserves between the new policy or certificate and the original policy or certificate; or

4) By an alternative program (such as underwriting concessions) developed by the insurer that meets the intent of this Section if the program is filed with and approved by the Director.

d) An insurer is not required to notify policyholders of a new proprietary policy series created and filed for use in a limited distribution channel. For purposes of this subsection, "limited distribution channel" means through a discrete entity, such as a financial institution or brokerage, for which specialized products are available that are not available for sale to the general public. Policyholders that purchased such a proprietary policy shall be notified when a new long-term care policy series that provides coverage for new long-term care services or providers that are material in nature is made available to that limited distribution channel.

e) Policies issued pursuant to this Section shall be considered exchanges and not replacements. These exchanges shall not be subject to Sections 2012.90 and 2012.123 of this Part, and the reporting requirements of Section 2012.95(a) to (d) of this Part.

f) When the policy is offered through an employer, labor organization or professional, trade or occupational association, the required notification in subsection (a) shall be made to the offering entity. However, if the policy is issued to a group defined in Section 351A-1(e)(4) of the Code, the notification shall be made to each certificateholder.

g) Nothing in this Section shall prohibit an insurer from offering any policy, rider, certificate or coverage change to any policyholder or certificateholder. However, upon request, any policyholder may apply for currently available coverage that includes the new services or providers. The insurer may require that policyholders meet all eligibility requirements, including underwriting and payment of the required premium to add new services or providers.

h) This Section does not apply to life insurance policies or riders containing accelerated long-term care benefits.

(Source: Added at 31 Ill. Reg. _____, effective _____)

Section 2012.126~~124~~ Right to Reduce Coverage and Lower Premiums ~~Appropriateness of Recommended Purchase~~

a) Every long-term care insurance policy and certificate shall include a provision that allows the policyholder or certificateholder to reduce coverage and lower the policy or certificate premium in at least one of the following ways:

1) Reducing the maximum benefit; or

2) Reducing the daily, weekly or monthly benefit amount.

b) The insurer may also offer other reduction options that are consistent with the policy or certificate design or the carrier's administrative processes.

c) The provision shall include a description of the ways in which coverage may be reduced and the process for requesting and implementing a reduction in coverage.

d) The age to determine the premium for the reduced coverage shall be based on the age used to determine the premiums for the coverage currently in force.

e) The insurer may limit any reduction in coverage to plans or options available for that policy form and to those for which benefits will be available after consideration of claims paid or payable.

f) If a policy or certificate is about to lapse, the insurer shall provide a written reminder to the policyholder or certificateholder of his or her right to reduce

coverage and premiums in the notice required by Section 2012.55(a)(3) of this Part.

g) This Section does not apply to life insurance policies or riders containing accelerated long-term care benefits.

h) The requirements of this Section shall apply to any long-term care policy issued in this State on or after July 2008.

~~In recommending the purchase or replacement of any traditional long-term care insurance policy or certificate, an insurance producer shall make efforts to determine the appropriateness of a recommended purchase or replacement.~~

(Source: Section 2012.124 renumbered to Section 2012.126 and amended at 31 Ill. Reg. _____, effective _____)

Section 2012.127 ~~Requirement to Offer~~ Nonforfeiture Benefit Requirement

a) ~~No policy or certificate may be delivered or issued for delivery in this State unless the policy or certificate includes a written offer at the time of issue for nonforfeiture benefits to the defaulting or lapsing policyholder or certificate holder.~~ This Section does not apply to life insurance policies or riders containing accelerated ~~traditional~~ long-term care benefits.

b) To comply with the requirement to offer a nonforfeiture benefit pursuant to Section 2012.86 of this Part:

1) A policy or certificate offered with nonforfeiture benefits shall have coverage elements, eligibility, benefit triggers and benefit length that are the same as coverage to be issued without nonforfeiture benefits. The nonforfeiture benefit included in the offer shall be the benefit described in Section 2012.127(e); and ~~(c).~~

2) The offer shall be in writing if the nonforfeiture benefit is not otherwise described in the Outline of Coverage or other materials given to the prospective policyholder.

c) If the offer required to be made under Section 2012.86 of this Part is rejected, the insurer shall provide the contingent benefit upon lapse described in this Section.

Even if this offer is accepted for a policy with a fixed or limited premium paying period, the contingent benefit on lapse in subsection (d)(3) shall still apply.

d~~b~~) After rejection of the offer required under Section 2012.86 of this Part, for individual and group policies without nonforfeiture benefits issued after~~After~~ July 1, 2002, ~~if the offer of a nonforfeiture benefit is rejected,~~ the insurer shall provide the contingent benefit upon lapse ~~as follows~~:

1) In the event a group policyholder elects to make the nonforfeiture benefit an option to the certificateholder, a certificate shall provide either the nonforfeiture benefit or the contingent benefit upon lapse.

2~~1~~) A~~The~~ contingent benefit on lapse shall be triggered every time an insurer increases the premium rates to a level that results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth below based on the insured's issue age, and the policy or certificate lapses within 120 days of the due date of the premium so increased. Unless otherwise required, policyholders shall be notified at least 30 days prior to the due date of the premium reflecting the rate increase.

Triggers for a Substantial Premium Increase

Issue Age	Percent Increase Over Initial Premium
29 and under	200%
30-34	190%
35-39	170%
40-44	150%
45-49	130%
50-54	110%
55-59	90%
60	70%
61	66%
62	62%
63	58%
64	54%
65	50%
66	48%

67	46%
68	44%
69	42%
70	40%
71	38%
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%
82	18%
83	17%
84	16%
85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

3) A contingent benefit on lapse shall also be triggered for policies with a fixed or limited premium paying period every time an insurer increases the premium rates to a level that results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth below based on the insured's issue age, the policy or certificate lapsing within 120 days after the due date of the premium increase, and the ratio in subsection (d)(5)(B) being 40% or more. Unless otherwise required, policyholders shall be notified at least 30 days prior to the due date of the premium reflecting the rate increase.

Triggers for a Substantial Premium Increase

Issue Age	Percent Increase Over Initial Premium

Under 65	50%
65-80	30%
Over 80	10%

This provision shall be in addition to the contingent benefit provided by subsection (d)(2) and, when both are triggered, the benefit provided shall be at the option of the insure.

4~~2~~) On or before the effective date of a substantial premium increase as defined in subsection ~~Section 2012.127~~(d)(2)~~(b)(1)~~, the insurer shall:

A) Offer to reduce policy benefits provided by the current coverage without the requirement of additional underwriting so that required premium payments are not increased;

B) Offer to convert the coverage to a paid-up status with a shortened benefit period in accordance with the terms of subsection~~Section 2012.127~~ (e)~~(c)~~. This option may be elected at any time during the 120-day period referenced in subsection~~Section 2012.127~~(d)(2)~~(b)(1)~~; and

C) Notify the policyholder or certificateholder that a default or lapse at any time during the 120-day period referenced in subsection ~~Section 2012.127~~(d)(2)~~(b)(1)~~ shall be deemed to be the election of the offer to convert in subsection ~~Section 2012.127~~(d)(4) unless the automatic option in subsection (d)(5)(C) applies~~(b)(2)(B)~~.

~~3) In the event a group policyholder elects to make the nonforfeiture benefit an option to the certificateholder, a certificate shall provide either the nonforfeiture benefit or the contingent benefit upon lapse.~~

5) On or before the effective date of a substantial premium increase, as defined in subsection (d)(3), the insurer shall:

A) Offer to reduce policy benefits provided by the current coverage without the requirement of additional underwriting so that required premium payments are not increased;

B) Offer to convert the coverage to a paid-up status when the amount payable for each benefit is 90% of the amount payable in effect immediately prior to lapse times the ratio of the number of completed months of paid premiums divided by the number of months in the premium paying period. This option may be elected at any time during the 120-day period referenced in subsection (d)(3); and

C) Notify the policyholder or certificateholder that a default or lapse at any time during the 120-day period referenced in subsection (d)(3) shall be deemed to be the election of the offer to convert in subsection (d)(5)(B) if the ratio is 40% or more.

e~~c~~) Benefits continued as nonforfeiture benefits, including contingent benefits upon lapse in accordance with subsection (d)(2), but not subsection (d)(3), are described as follows:

1) For purposes of this Section, attained age rating is defined as a schedule of premiums starting from the issue date which increases age at least 1% per year prior to age 50, and at least 3% per year beyond age 50.

2) For purposes of this Section, the nonforfeiture ~~benefit including the contingent benefit upon lapse~~ shall be a shortened benefit period providing paid-up traditional long-term care insurance coverage after lapse. The same benefits (amounts and frequency in effect at the time of lapse but not increased thereafter) will be payable for a qualifying claim, but the lifetime maximum dollars or days of benefits shall be determined as specified in subsection (e)~~(c)~~(3) of this Section.

3) The standard nonforfeiture credit ~~for an offered nonforfeiture benefit~~ will be equal to 100% of the sum of all premiums paid, including the premiums paid prior to any changes in benefits. The insurer may offer additional shortened benefit period options, as long as the benefits for each duration equal or exceed the standard nonforfeiture credit for that duration. However, the minimum nonforfeiture credit shall not be less than 30 times the daily nursing home benefit at the time of lapse. In either event, the calculation of the nonforfeiture credit is subject to the limitation of subsection (f)~~(d)~~ of this Section.

4) No policy or certificate which includes a nonforfeiture benefit shall begin a nonforfeiture benefit later than the end of the third year following the policy or certificate issue date except that, for a policy or certificate with attained age rating, the nonforfeiture benefit shall begin on the earlier of:

A) The end of the tenth year following the policy or certificate issue date; or

B) The end of the second year following the date the policy or certificate is no longer subject to attained age rating.

5) Nonforfeiture credits may be used for all care and services qualifying for benefits under the terms of the policy or certificate, up to the limits specified in the policy or certificate.

f~~d~~) All benefits paid by the insurer while the policy or certificate is in premium paying status and in the paid up status will not exceed the maximum benefits which would have been payable if the policy or certificate had remained in premium paying status.

g~~e~~) There shall be no difference in the minimum nonforfeiture benefits as required under~~which are offered under the requirements of~~ this Section for group and individual policies.

h~~f~~) The requirements of this Section shall apply to any ~~traditional~~ long-term care policy issued in this State, and shall apply as follows~~except for~~:

1) Except as provided in subsections (h)(2) and (3), the provisions of this Section apply to any long-term care policy issued in this State on or after July 2007.~~Life insurance policies or riders containing accelerated long-term care benefits; or~~

2) For certificates issued on or after July 2007, under a group long-term care insurance policy issued to one or more employers or labor organizations, or to a trust or to the trustee or trustees of a fund established by one or more employers or labor organizations, or a combination thereof, for employees or former employees, or a combination thereof, or for members or former members, or a combination thereof, of the labor organizations, which policy was in force in July 2007, the provisions of this Section shall

not apply. ~~A group traditional long-term care insurance policy that was in force prior to July 1, 2002.~~

3) The last sentence in subsection (c) and all of subsections (d)(3) and (d)(4) shall apply to any long-term care insurance policy or certificate issued in this State after January 2008, except new certificates on a group policy issued to one or more employers or labor organizations, or to a trust or to the trustee or trustees of a fund established by one or more employers or labor organizations, or a combination thereof, for employees or former employees, or a combination thereof, or for members or former members, or a combination thereof, of the labor organizations, after July 2008.

i~~g~~) Premiums charged for a policy or certificate containing nonforfeiture benefits or a contingent benefit on lapse shall be subject to the loss ratio requirements of Sections~~Section~~ 2012.110 or 2012.112 of this Part, whichever is applicable, treating the policy as a whole.

j~~h~~) To determine whether contingent nonforfeiture upon lapse provisions are triggered under subsection~~Section 2012.127~~(d)(2) or (d)(3)~~(b)(1)~~, a replacing insurer that purchased or otherwise assumed a block or blocks of long-term care insurance policies from another insurer shall calculate the percentage increase based on the initial annual premium paid by the insured when the policy was first purchased from the original insurer.

k~~i~~) A nonforfeiture benefit for qualified long-term care insurance contracts that are level premium contracts shall be offered that meets the following requirements:

1) The nonforfeiture provision shall be appropriately captioned;

2) The nonforfeiture provision shall provide a benefit available in the event of a default in the payment of any premiums and shall state that the amount of the benefit may be adjusted subsequent to being initially granted only as necessary to reflect changes in claims, persistency and interest as reflected in changes in rates for premium paying contracts approved by the Director for the same contract form; and

3) The nonforfeiture provision shall provide at least one of the following:

A) Reduced paid-up insurance;

B) Extended term insurance;

C) Shortened benefit period; or

D) Other similar offerings approved by the Director.

(Source: Amended at 31 Ill. Reg. _____, effective _____)

Section 2012.128 Standards for Benefit Triggers

a) A ~~traditional~~ long-term care insurance policy shall condition the payment of benefits on a determination of the insured's ability to perform activities of daily living and on cognitive impairment. Eligibility for the payment of benefits shall not be more restrictive than requiring either a deficiency in the ability to perform not more than 3 of the activities of daily living or the presence of cognitive impairment.

b) Insurers may use activities of daily living to trigger covered benefits as long as they are defined in the policy. Activities of daily living shall include but not be limited to the following, as defined in Section 2012.40 of this Part and in the policy:

1) Bathing;

2) Continence;

3) Dressing;

4) Eating;

5) Toileting; and

6) Transferring.

c) An insurer may use additional provisions for the determination of when benefits are payable under a policy or certificate; however, the provisions shall not restrict, and are not in lieu of, the requirements contained in subsections (a) and (b) of this Section.

d) For purposes of this Section the determination of a deficiency shall not be more restrictive than:

1) Requiring the hands-on assistance of another person to perform the prescribed activities of daily living; or

2) If the deficiency is due to the presence of a cognitive impairment, supervision or verbal cueing by another person is needed in order to protect the insured or others.

e) Assessments of activities of daily living and cognitive impairment shall be performed by licensed or certified professionals, such as physicians, nurses or social workers.

f) Long~~Traditional long~~-term care insurance policies shall include a clear description of the process for appealing and resolving benefit determinations.

g) The requirements set forth in this Section shall apply as follows:

1) Except as provided in subsection (g)(2) of this Section, the provisions of this Section apply to a ~~traditional~~ long-term care policy issued in this State.

2) For certificates issued under a ~~traditional~~ group ~~traditional~~ long-term care insurance policy as defined in Section 351A-1(e)(1) of the Code~~2012.30 of this Part~~, the provisions of this Section shall not apply.

(Source: Amended at 31 Ill. Reg. _____, effective _____)

Section 2012.129 Additional Standards for Benefit Triggers for Qualified Long-Term Care

a) A qualified long-term care insurance contract shall pay only for qualified long-term care services received by a chronically ill individual provided pursuant to a plan of care prescribed by a licensed health care practitioner~~, as defined in Section 2012.40~~.

b) A qualified long-term care insurance contract shall condition the payment of benefits on a determination of the insured's inability to perform activities of daily

living for an expected period of at least 90 days due to a loss of functional capacity or to severe cognitive impairment.

c) Certifications regarding activities of daily living and cognitive impairment required pursuant to subsection (b) of this Section shall be performed by the following licensed or certified professionals: physicians, registered professional nurses, licensed social workers, or other individuals who meet requirements prescribed by the Secretary of the Treasurya licensed health care practitioner, as defined in Section 2012.40.

d) Certifications required pursuant to subsection (b) of this Section may be performed by a licensed health care practitioner at the direction of the carrier as is reasonably necessary with respect to a specific claim, except that when a licensed health care practitioner has certified that an insured is unable to perform activities of daily living for an expected period of at least 90 days due to a loss of functional capacity and the insured is in claim status, the certification may not be rescinded and additional certifications may not be performed until after the expiration of the 90 day period.

e) Qualified long-term care insurance contracts shall include a clear description of the process for appealing and resolving disputes with respect to benefit determinations.

(Source: Amended at 31 Ill. Reg. _____, effective _____)

Section 2012.130 Standard Format Outline of Coverage Requirements

This Section implements, interprets and makes specific the provisions of Section 351A-8 of the Illinois Insurance Code [215 ILCS 5/351A-8] in prescribing a standard format and the content of an outline of coverage.

a) The outline of coverage shall be a free-standing document, using no smaller than ten point type.

b) The outline of coverage shall contain no material of an advertising naturenot contained within the policy itself.

c) Text which is capitalized or underscored in the standard format outline of coverage may be emphasized by other means which provide prominence

equivalent to such capitalization or underscoring.

d) Use of the text and sequence of text of the standard format outline of coverage is mandatory unless otherwise specifically indicated.

e) The standard format, including style, arrangement and overall appearance, and the content of an outline of coverage appears in Exhibit C of this Part.

(Source: Amended at 31 Ill. Reg. _____, effective _____)

Section 2012.140 Requirement to Deliver Shopper's Guide

a) A ~~traditional~~ long-term care insurance shopper's guide in the format developed by the National Association of Insurance Commissioners, or a guide developed or approved by the Director shall be provided to all prospective applicants of a ~~traditional~~ long-term care insurance policy or certificate.

1) In the case of ~~an~~ insurance producer solicitations, a producer must deliver the shopper's guide prior to the presentation of an application or enrollment form.

2) In the case of direct response solicitations, the shopper's guide must be presented in conjunction with any application or enrollment form.

b) Life insurance policies or riders containing accelerated traditional long-term care benefits are not required to furnish the above-referenced guide, but shall furnish the policy summary required under Section 351A-9.1 of the Code~~2012.60(f)(1) of this Part~~.

(Source: Amended at 31 Ill. Reg. _____, effective _____)

Section 2012.150 Penalties

In addition to any other penalties provided by the laws of this State any insurer and any insurance producer found to have violated any requirement of this State relating to the regulation of ~~traditional~~ long-term care insurance or the marketing of such insurance shall be subject to a fine of up to 3 times the amount of any commissions paid for each policy involved in the violation or up to $10,000, whichever is greater.

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(Source: Amended at 31 Ill. Reg. _____, effective _____)

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Section 2012.EXHIBIT A Replacement Notice for Other Than Direct Response Solicitations

NOTICE TO APPLICANT REGARDING REPLACEMENT OF INDIVIDUAL ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE

[Insurance Company Name and Address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing accident and sickness or ~~traditional~~ long-term care insurance policy to be issued by [Company Name] Insurance Company. Your new policy provides 30~~10~~ days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all accident and sickness or ~~traditional~~ long-term care insurance coverage you have, and terminate your policy only if, after due consideration, you find that purchase of this ~~traditional~~ long-term care coverage is a wise decision.

STATEMENT TO APPLICANT BY AGENT [BROKER OR OTHER REPRESENTATIVE]:
(Use additional sheets as necessary)

I have reviewed your current medical or health insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention:

1. Health conditions which you may presently have (preexisting conditions), may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. The insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent

(depleted) under the original policy.

3. If you are replacing existing ~~traditional~~ long-term care insurance coverage you may wish to secure the advice of your present insurer or its insurance producer regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

4. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

_____
(Signature of Insurance Producer~~, Broker or Other Representative Agent~~) [Type Name and Address of Insurance Producer~~ or Other Representative of Agent or Broker~~]

The above "Notice to Applicant" was delivered to me on:

_____ _____
(Applicant's Signature) (Date)

(Source: Amended at 31 Ill. Reg. _____, effective _____)

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Section 2012.EXHIBIT B Replacement Notice for Direct Response Solicitations

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE

[Insurance Company's Name and Address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing accident and sickness or ~~traditional~~ long-term care insurance and replace it with the ~~traditional~~ long-term care insurance policy delivered herewith issued by [Company Name] Insurance Company. Your new policy provides 30 days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it will all accident and sickness or ~~traditional~~ long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this ~~traditional~~ long-term coverage is a wise decision.

1. Health conditions which you may presently have (preexisting conditions), may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new preexisting conditions or probation periods. Your insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

3. If you are replacing existing ~~traditional~~ long-term care insurance coverage you may wish to secure the advice of your present insurer or its insurance producer regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

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4. [To be included only if the application is attached to the policy.] If, after due consideration, you still wish to terminate you present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to [Company Name and Address] within 30 days if any information is not correct and complete, or if any past medical history has been left out of the application.

_____
(Company Name)

(Source: Amended at 31 Ill. Reg. _____, effective _____)

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Section 2012.EXHIBIT C Standard Format Outline of Coverage

[COMPANY NAME]

[ADDRESS - CITY & STATE]

[TELEPHONE NUMBER]

~~TRADITIONAL~~ LONG-TERM CARE INSURANCE

OUTLINE OF COVERAGE

[Policy Number or Group Master Policy and Certificate Number]

[Except for policies or certificates which are guaranteed issue, the following caution statement, or language substantially similar, must appear as follows in the outline of coverage.]

~~Traditional long-term care insurance policies or certificates sold after July 1, 1995 that are not under the Illinois Long-Term Care Partnership Program shall include a statement on the outline of coverage, the policy or certificate application, and the front page of the policy or certificate in bold type and in a separate box as follows: "THIS POLICY (CERTIFICATE) IS NOT APPROVED FOR MEDICAID ASSET PROTECTION UNDER THE ILLINOIS LONG-TERM CARE PARTNERSHIP PROGRAM. HOWEVER, THIS POLICY (CERTIFICATE) IS AN APPROVED TRADITIONAL LONG-TERM CARE POLICY (CERTIFICATE) UNDER STATE INSURANCE REGULATIONS. FOR INFORMATION ABOUT POLICIES AND CERTIFICATES APPROVED UNDER THE ILLINOIS TRADITIONAL LONG-TERM CARE PARTNERSHIP PROGRAM, CALL THE SENIOR HELPLINE AT THE DEPARTMENT ON AGING AT 1-800-252-8966."~~

Caution: The issuance of this ~~traditional~~ long-term care insurance [policy] [certificate] is based upon your responses to the questions on your application. A copy of your [application] [enrollment form] [is enclosed] [was retained by you when you applied]. If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If for any reason any of your answers are incorrect, contact the company at this address: [insert address]

1. This policy is [an individual policy of insurance] ([a group policy] which was issued in the [indicate jurisdiction in which group policy was issued]).

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2. PURPOSE OF OUTLINE OF COVERAGE. This outline of coverage provides a very brief description of the important features of the policy. You should compare this outline of coverage to outlines of coverage for other policies available to you. This is not an insurance contract, but only a summary of coverage. Only the individual or group policy contains governing contractual provisions. This means that the policy or group policy sets forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you READ YOUR POLICY (OR CERTIFICATE) CAREFULLY!

3. FEDERAL TAX CONSEQUENCES.

This [POLICY] [CERTIFICATE] is intended to be a federally tax-qualified ~~traditional~~ long-term care insurance contract within the meaning of the Internal Revenue Code of 1986, as amended (26 USC 7702B(b)).

OR

Federal Tax Implications of this [POLICY] [CERTIFICATE]. This [POLICY] [CERTIFICATE] is not intended to be a federally tax-qualified ~~traditional~~ long-term care insurance contract within the meaning of the Internal Revenue Code of 1986 as amended (26 USC 7702B(b)). Benefits received under the [POLICY] [CERTIFICATE] may be taxable as income.

4. TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE CONTINUED IN FORCE OR DISCONTINUED.

a) [For ~~traditional~~ long-term care health insurance policies or certificates include one of the following permissible policy renewability provisions:]

1) Policies and certificates that are guaranteed renewable shall contain the following statement: RENEWABILITY: THIS POLICY [CERTIFICATE] IS GUARANTEED RENEWABLE. This means you have the right, subject to the terms of your policy [certificate], to continue this policy as long as you pay your premiums on time. [Company Name] cannot change any of the terms of your policy on its own, except that, in the future, IT MAY INCREASE THE PREMIUM YOU PAY.

2) Policies and certificates that are noncancellable shall contain the following statement: RENEWABILITY: THIS POLICY [CERTIFICATE] IS NONCANCELLABLE. This means that you have the right, subject to the terms of your policy, to continue this policy as long as you pay your premiums on time. [Company Name] cannot change any of the terms of your policy on its own and cannot change the premium you currently pay. However, if your policy contains an inflation protection feature where you choose to increase your benefits, [Company Name] may increase your premium at that time for those additional benefits.

b) [For group coverage, specifically include continuation/conversion provisions applicable to the certificate and group policy;]

c) [Include waiver of premium provisions or state that there are no such provisions].~~;~~

5. TERMS UNDER WHICH THE COMPANY MAY CHANGE PREMIUMS. [In bold type larger than the maximum type required to be used for the other provisions of the outline of coverage, state whether or not the company has a right to change the premium, and if a right exists, describe clearly and concisely each circumstance under which the premium may change.]

6. TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE RETURNED AND PREMIUM REFUNDED.

a) [Provide a brief description of the right to return - "free look" provision of the policy.]

b) [Include a statement that the policy either does or does not contain provisions providing for a refund or partial refund of premium upon the death of an insured or surrender of the policy or certificate. If the policy contains such provisions, include a description of them.]

7. THIS IS NOT MEDICARE SUPPLEMENT COVERAGE. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the insurance company.

a) [For insurance producers] Neither [insert company name] nor its insurance

producers represent Medicare, the federal government or any state government.

b) [For direct response] [insert company name] is not representing Medicare, the federal government or any state government.

8. ~~TRADITIONAL~~ LONG-TERM CARE COVERAGE. Policies of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital, such as in a nursing home, in the community or in the home.
This policy provides coverage in the form of a fixed dollar indemnity benefit for covered long-term care expenses, subject to policy [limitations] [waiting periods] and [coinsurance] requirements. [Modify this paragraph if the policy is not an indemnity policy.]

9. BENEFITS PROVIDED BY THIS POLICY.

a) [Covered services, related deductible(s), waiting periods, elimination periods and benefit maximums.]

b) [Institutional benefits, by skill level.]

c) [Non-institutional benefits, by skill level.]

d) Eligibility for Payment of Benefits.

[Activities of daily living and cognitive impairment shall be used to measure an insured's need for ~~traditional~~ long-term care and must be defined and described as part of the outline of coverage.]

[Any additional benefit triggers must also be explained in this Section. If these benefit triggers differ for different benefits, explanation of the triggers should accompany each benefit description. If an attending physician or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, this too must be specified.]

10. LIMITATIONS AND EXCLUSIONS.
[Describe:

a) Preexisting conditions;

b) Non-eligible facilities/provider;

c) Non-eligible levels of care (e.g., unlicensed providers, care or treatment provided by a family member, etc.);

d) Exclusions/exceptions;

e) Limitations.]

[This Section should provide a brief specific description of any policy provisions which limit, exclude, restrict, reduce, delay, or in any other manner operate to qualify payment of the benefits described in number 9~~(8)~~ above.]

THIS POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG-TERM CARE NEEDS.

11. RELATIONSHIP OF COST OF CARE AND BENEFITS. Because the cost of ~~traditional~~ long-term care services will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted. [As applicable, indicate the following:

a) That the benefit level will not increase over time;

b) Any automatic benefit adjustment provisions;

c) Whether the insured will be guaranteed the option to buy additional benefits and the basis upon which benefits will be increased over time if not by a specified amount or percentage;

d) If there is such a guarantee, include whether additional underwriting or health screening will be required, the frequency and amounts of the upgrade options, and any significant restrictions or limitations;

e) And finally, describe whether there will be any additional premium charge imposed, and how that is to be calculated.]

12. ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS. [State that the policy provides coverage for insureds clinically diagnosed as

having Alzheimer's disease or related degenerative and dementing illnesses. Specifically describe each benefit screen or other policy provision which provides preconditions to the availability of policy benefits for such an insured.]

13. PREMIUM.

[a) State the total annual premium for the policy;

b) If the premium varies with an applicant's choice among benefit options, indicate the portion of annual premium which corresponds to each benefit option.]

14. ADDITIONAL FEATURES.

[a) Indicate if medical underwriting is used;

b) Describe other important features.]

15. CONTACT THE STATE SENIOR HEALTH INSURANCE ASSISTANCE PROGRAM IF YOU HAVE GENERAL QUESTIONS REGARDING ~~TRADITIONAL~~ LONG-TERM CARE INSURANCE. CONTACT THE INSURANCE COMPANY IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR ~~TRADITIONAL~~ LONG-TERM CARE INSURANCE POLICY OR CERTIFICATE.

16. GRAPHIC COMPARISON.
A graphic comparison of the benefit levels of a policy that increases benefits over the policy period with a policy that does not increase benefits. The graphic comparison shall show benefit levels over at least a 20 year period.

(Source: Amended at 31 Ill. Reg. _____, effective _____)

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Section 2012.EXHIBIT D Rescission Reporting Format

RESCISSION REPORTING FORMS FOR
~~TRADITIONAL~~ LONG-TERM CARE POLICIES
FOR THE STATE OF ILLINOIS
FOR THE REPORTING YEAR 20[ ]

Company Name: _____

Address: _____

_____

Phone Number: _____

Due: March 1~~June 30~~ annually

Instructions:
The purpose of this form is to report all rescissions of ~~traditional~~ long-term care insurance policies or certificates. Those rescissions voluntarily effectuated by an insured are not required to be included in this report. Please furnish one form per rescission.

Policy Form #	Policy and Certificate #	Name of Insured	Date of Policy Issuance	Date/s Claim/s Submitted	Date of Rescission

Detailed reason for rescission:

_____

_____

_____

_____

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_____
Signature

_____
Name and Title (please type)

_____
Date

(Source: Amended at 31 Ill. Reg. _____, effective _____)

Section 2012.EXHIBIT E Class of Insurance - Accident and Health (Repealed)

~~Course of Study Content Requirements for a course entitled "Traditional Long-Term Care Insurance Policy":~~

~~a) Reasons for the interest in traditional long-term care~~

~~b) Sources for providing traditional long-term care~~

~~c) Medicaid~~

~~d) Life-Care facilities~~

~~e) Insurance policies providing traditional long-term care coverage~~

(Source: Repealed at 31 Ill. Reg. _____, effective _____)

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Section 2012.EXHIBIT F ~~Traditional~~ Long-Term Care Insurance Personal Worksheet

People buy ~~traditional~~ long-term care insurance for many reasons. Some don't want to use their own assets to pay for ~~traditional~~ long-term care. Some buy insurance to make sure they can choose the type of care they get. Others don't want their family to have to pay for care or don't want to go on Medicaid. But ~~traditional~~ long-term care insurance may be expensive, and may not be right for everyone.

The company will ask you to fill out this worksheet to help you and the company decide if you should buy this policy. By State law, the insurance company must fill out part of the information on this worksheet.

Premium Information

Policy Form Number(s) _____

The premium for the coverage you are considering will be [$ _____ per month, or $ _____ per year,] [a one-time single premium of $ _____]

Type of Policy (noncancellable/guaranteed renewable): _____

The Company's Right to Increase Premiums: _____

[The company cannot raise your rates on this policy.] [The company has a right to increase premiums on this policy form in the future, provided it raises rates for all policies in the same class in this State.] [Insurers shall use appropriate bracketed statement. Rate guarantees shall not be shown on this form.]

Rate Increase History

The company has sold ~~traditional~~ long-term care insurance since [year] and has sold this policy since [year]. [The company has never raised its rates for any ~~traditional~~ long-term care policy it has sold in this State or any other state.] [The company has not raised its rates for this policy form or similar policy forms in this State or any other state in the last 10 years.] [The company has raised its premium rates on this policy form or similar policy forms in the last 10 years. Following is a summary of the rate increases.]

[The issuer shall list each premium increase it has instituted on this or similar policy forms in this State or any other state during the last 10 years. The list shall provide the policy form, the

calendar years the form was available for sale, and the calendar year and the amount (percentage) of each increase.]

[The insurer shall provide minimum and maximum percentages if the rate increase is variable by rating characteristics. The insurer may provide, in a fair manner, additional explanatory information as appropriate.]

Questions Related to Your Income

How will you pay each year's premium?

☐ From my Income ☐ From my Savings/Investments ☐ My Family will Pay

[☐ Have you considered whether you could afford to keep this policy if the premiums were raised, for example, by 20%?]

What is your annual income? (check one)

☐ Under $10,000 ☐ $[10-20,000] ☐ $[20-30,000]
☐ $[30-50,000] ☐ Over $50,000

How do you expect your income to change over the next 10 years? (check one)

☐ No change ☐ Increase ☐ Decrease

If you will be paying premiums with money received only from your own income, a rule of thumb is that you may not be able to afford this policy if the premiums will be more than 7% of your income.

Will you buy inflation protection? (check one) ☐ Yes ☐ No

If not, have you considered how you will pay for the difference between future costs and your daily benefit amount?

☐ From my Income ☐ From my Savings/Investments ☐ My Family will Pay

The national average annual cost of care in [insert year] was [insert $ amount], but this figure varies across the country. In ten years the national average annual cost would be about [insert $ amount] if costs increase 5% annually.

What elimination period are you considering? Number of day _____ Approximate cost $ _____ for that period of care.

How are you planning to pay for your care during the elimination period? (check one)

☐ From my Income ☐ From my Savings/Investments ☐ My Family will Pay

Questions Related to Your Savings and Investments

Not counting your home, about how much are all of your assets (your savings and investments) worth? (check one)

☐ Under $20,000 ☐ $20,000-$30,000 ☐ $30,000-$50,000 ☐ Over $50,000

How do you expect your assets to change over the next ten years? (check one)

☐ Stay about the same ☐ Increase ☐ Decrease

If you are buying this policy to protect your assets and your assets are less than $30,000, you may wish to consider other options for financing your ~~traditional~~ long-term care.

Disclosure Statement

☐ The answers to the questions above describe my financial situation

Or

☐ I choose not to complete this information

(Check one.)

☐ I acknowledge that the carrier and/or its agent (below) has reviewed this form with me including the premium, premium rate increase history and potential for premium increases in the future. [For direct mail situations, use the following: I acknowledge that I have reviewed this form including their premium, premium rate increase history and potential for premium increases in the future.] I understand the above disclosures. **I understand that the rates for this policy may increase in the future.** (This box must be checked).

Signed: _____ _____

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(Applicant) (Date)

[☐ I explained to the applicant the importance of completing this information.

Signed: _____ _____
(Insurance Producer) (Date)

Insurance Producer's Printed Name: _____]

[Choose the appropriate sentences depending on whether this is a direct mail or insurance producer sale.]

[In order for us to process your application, please return this signed statement to [name of company], along with your application.]

[My insurance producer has advised me that this policy does not appear to be suitable for me. However, I still want the company to consider my application.]

Signed: _____ _____
(Applicant) (Date)

~~Choose the appropriate sentences depending on whether this is a direct mail or insurance producer sale.~~

The company may contact you to verify your answers.

[When the ~~Traditional~~ Long-Term Care Insurance Personal Worksheet is furnished to employees and their spouses under employer group policies, the text from the heading "Disclosure Statement" to the end of the page may be removed.]

(Source: Amended at 31 Ill. Reg. _____, effective _____)

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Section 2012.EXHIBIT G Things You Should Know Before You Buy ~~Traditional~~ Long-Term Care Insurance

~~Traditional~~ Long-Term Care Insurance	• A ~~traditional~~ long-term care insurance policy may pay most of the costs for your care in a nursing home. Many policies also pay for care at home or other community settings. Since policies can vary in coverage, you should read this policy and make sure you understand what it covers before you buy it. • [You should not buy this insurance policy unless you can afford to pay the premiums every year.] [Remember that the company can increase premiums in the future.] [For single premium policies, delete this bullet; for noncancellable policies, delete the second sentence only.] ~~For single premium policies, delete this bullet; for noncancellable policies, delete the second sentence only.~~ • The personal worksheet includes questions designed to help you and the company determine whether this policy is suitable for your needs.
Medicare	• Medicare does not pay for most ~~traditional~~ long-term care
Medicaid	• Medicaid will generally pay for ~~traditional~~ long-term care if you have very little income and few assets. You probably should not buy this policy if you are now eligible for Medicaid. • Many people become eligible for Medicaid after they have used up their own financial resources by paying for ~~traditional~~ long-term care services. • When Medicaid pays your spouse's nursing home bills, you are allowed to keep your house and furniture, a living allowance, and some of your joint assets. • Your choice of ~~traditional~~ long-term care services may be limited if you are receiving Medicaid. To learn more about Medicaid, contact your local or State Medicaid agency.

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Shopper's Guide	•	Make sure the insurance company or insurance producer gives you a copy of a book called the National Association of Insurance Commissioners' "Shopper's Guide to ~~Traditional~~ Long-Term Care Insurance." Read it carefully. If you have decided to apply for ~~traditional~~ long-term care insurance, you have the right to return the policy within 30 days and get back any premium you have paid if you are dissatisfied for any reason or choose not to purchase the policy.
Counseling	•	Free counseling and additional information about ~~traditional~~ long-term care insurance is available through your State's insurance counseling program. Contact your State insurance department or Department on Aging for more information about the senior health insurance counseling program in your State.
Facilities	•	Some long-term care insurance contracts provide for benefit payments in certain facilities only if they are licensed or certified, such as in assisted living centers. However, not all states regulate these facilities in the same way. Also, many people move to a different state from where they purchased their long-term care insurance policy. Read the policy carefully to determine what types of facilities qualify for benefit payments, and to determine that payment for a covered service will be made if you move to a state that has a different licensing scheme for facilities than the one in which you purchased the policy.

(Source: Amended at 31 Ill. Reg. _____, effective _____)

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Section 2012.EXHIBIT H ~~Traditional~~ Long-Term Care Insurance Suitability Letter

Dear [Applicant]:

Your recent application for ~~traditional~~ long-term care insurance included a "personal worksheet", which asked questions about your finances and your reasons for buying ~~traditional~~ long-term care insurance. For your protection, State law requires us to consider this information when we review your application, to avoid selling a policy to those who may not need coverage.

[Your answers indicate that ~~traditional~~ long-term care insurance may not meet your financial needs. We suggest that you review the information provided along with your application, including the booklet "Shopper's Guide to Long-Term Care Insurance" and the page titled "Things You Should Know Before Buying Long-Term Care Insurance." Your State insurance department also has information about ~~traditional~~ long-term care insurance and may be able to refer you to a counselor free of charge who can help you decide whether to buy this policy.]

[You chose not to provide any financial information for us to review.]

We have suspended our final review of your application. If, after careful consideration, you still believe this policy is what you want, check the appropriate box below and return this letter to us within the next 60 days. We will then continue reviewing your application and issue a policy if you meet our medical standards.

If we do not hear from you within the next 60 days, we will close your file and not issue you a policy. You should understand that you will not have any coverage until we hear back from you, approve your application and issue you a policy.

Please check one box and return in the enclosed envelope.

☐ Yes, [although my worksheet indicates that ~~traditional~~ long-term care insurance may not be a suitable purchase,] I wish to purchase this coverage. Please resume review of my application. [Delete the phrase in brackets if the applicant did not answer the questions about income.]

~~Delete the phrase in brackets if the applicant did not answer the questions about income.~~

☐ No. I have decided not to buy a policy at this time.

APPLICANT'S SIGNATURE DATE

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Please return to [issuer] at [address] by [date].

(Source: Amended at 31 Ill. Reg. _____, effective _____)

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Section 2012.EXHIBIT I Claims Denial Reporting Form: Long-Term Care Insurance~~Format~~

For the State of Illinois For the Reporting Year of: _____

Company Name: _____ Due: June 30 annually

Company Address: _____

_____

Company NAIC Number: _____

Contact Person: _____ Phone Number: _____

Line of Business: ☐ Individual ☐ Group

Instructions

The purpose of this format is to report all ~~traditional~~ long-term care claim denials under in force ~~traditional~~ long-term care insurance policies. "Denied" means a claim that is not paid for any reason other than for claims not paid for failure to meet the waiting period or because of an applicable preexisting condition.

		State Data	Nationwide Data[1]
1	Total Number of ~~Traditional~~ Long-Term Care Claims Reported		
2	Total Number of ~~Traditional~~ Long-Term Care Claims Denied/Not Paid		
3	Number of Claims Not Paid due to Preexisting Condition Exclusion		
4	Number of Claims Not Paid due to Waiting (Elimination) Period Not Met		
5	Net Number of ~~Traditional~~ Long-Term Care Claims Denied for Reporting Purposes (Line 2 Minus Line 3 Minus Line 4)		
6	Percentage of ~~Traditional~~ Long-Term Care Claims Denied of Those Reported (Line 5 Divided By Line 1)		

7	Number of ~~Traditional~~ Long-Term Care Claims Denied due to:		
8	• ~~Traditional~~ Long-Term Care Services Not Covered under the Policy[2]		
9	• Provider/Facility Not Qualified under the Policy[3]		
10	Benefit Eligibility Criteria Not Met[4]		
11	• Other		

[1] The nationwide data may be viewed as a more representative and credible indicator where the data for claims and denied for your state are small in number.
[2] Example – home health care claim filed under a nursing home only policy.
[3] Example – a facility that does not meet the minimum level of care requirements or the licensing requirements as outlined in the policy.
[4] Example – a benefit trigger not met, certification by a licensed health care practitioner not provided, no plan of care.

(Source: Amended at 31 Ill. Reg. _____, effective _____)

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Section 2012.EXHIBIT J Potential Rate Increase Disclosure

Instructions:

This form provides information to the applicant regarding premium rate schedules, rate schedule adjustments, potential rate revisions, and policyholder options in the event of a rate increase.

Insurers shall provide all of the following information to the applicant:

~~Traditional~~ Long-Term Care Insurance

Potential Rate Increase Disclosure Form

1. [Premium Rate] [Premium Rate Schedules]: [Premium rate] [Premium rate schedules] that [is] [are] applicable to you and that will be in effect until a request is made and [filed] [approved] for an increase [is] [are] [on the application] [$].

2. The [premium] [premium rate schedule] for this policy [will be shown on the schedule page of] [will be attached to] your policy.

3. Rate Schedule Adjustments:

The company will provide a description of when premium rate or rate schedule adjustments will be effective (e.g., next anniversary date, next billing date, etc.) (fill in the blank):

_____

4. Potential Rate Revisions:

This policy is Guaranteed Renewable. This means that the rates for this product may be increased in the future. Your rates can NOT be increased due to your increasing age or declining health, but your rates may go up based on the experience of all policyholders with a policy similar to yours.

If you receive a premium rate or premium rate schedule increase in the future, you will be notified of the new premium amount and you will be able to exercise at least one of the following options:

- Pay the increased premium and continue your policy in force as is.

- Reduce your policy benefits to a level such that your premiums will not increase.
- (Subject to state law minimum standards.)
- Exercise your nonforfeiture option if purchased. (This option is available for purchase for an additional premium.)
- Exercise your contingent nonforfeiture rights.* (This option may be available if you do not purchase a separate nonforfeiture option.)

* **Contingent Nonforfeiture**

If the premium rate for your policy goes up in the future and you didn't buy a nonforfeiture option, you may be eligible for contingent nonforfeiture. Here's how to tell if you are eligible:

You will keep some ~~traditional~~ long-term care insurance coverage, if:

- Your premium after the increase exceeds your original premium by the percentage shown (or more) in the following table; and
- You lapse (not pay more premiums) within 120 days of the increase.

The amount of coverage (i.e., new lifetime maximum benefit amount) you will keep will equal the total amount of premiums you've paid since your policy was first issued. If you have already received benefits under the policy, so that the remaining maximum benefit amount is less than the total amount of premiums you've paid, the amount of coverage will be that remaining amount.

Except for this reduced lifetime maximum benefit amount, all other policy benefits will remain at the levels attained at the time of the lapse and will not increase thereafter.

Should you choose this Contingent Nonforfeiture option, your policy, with this reduced maximum benefit amount, will be considered "paid-up" with no further premiums due.

Example:

- You bought the policy at age 65 and paid the $1,000 annual premium for 10 years, so you have paid a total of $10,000 in premium.
- In the eleventh year, you receive a rate increase of 50%, or $500 for a new annual premium of $1,500, and you decide to lapse the policy (not pay any more premiums).
- Your "paid-up" policy benefits are $10,000 (provided you have at least $10,000 of benefits remaining under your policy.)

Contingent Nonforfeiture
Cumulative Premium Increase over Initial Premium
That qualifies for Contingent Nonforfeiture

(Percentage increase is cumulative from date of original issue.
It does NOT represent a one-time increase.)

Issue Age	Percent Increase Over Initial Premium
29 and under	200%
30-34	190%
35-39	170%
40-44	150%
45-49	130%
50-54	110%
55-59	90%
60	70%
61	66%
62	62%
63	58%
64	54%
65	50%
66	48%
67	46%
68	44%
69	42%
70	40%
71	38%
72	36%
73	34%
74	32%

75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%
82	18%
83	17%
84	16%
85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

[The following contingent nonforfeiture disclosure need only be included for those limited pay policies to which Section 2012.127(d)(3) and (d)(5) of this Part are applicable.]

In addition to the contingent nonforfeiture benefits described in this Exhibit, the following reduced paid-up contingent nonforfeiture benefit is an option in all policies that have a fixed or limited premium payment period, even if you selected a nonforfeiture benefit when you bought your policy. If both the reduced paid up benefit AND the contingent benefit described are triggered by the same rate increase, you can choose either of the two benefits.

You are eligible for the reduced paid-up contingent nonforfeiture benefit when all three conditions shown below are met:

1. The premium you are required to pay after the increase exceeds your original premium by the same percentage or more shown in the following chart:

Triggers for a Substantial Premium Increase

Issue Age	Percent Increase Over Initial Premium
Under 65	50%
65-80	30%
Over 80	10%

2. You stop paying your premiums within 120 days after the premium increase took effect; AND

3. The ratio of the number of months you already paid premiums is 40% or more than the number of months you originally agreed to pay.

If you exercise this option, your coverage will be converted to reduced paid-up status. That means there will be no additional premiums required. Your benefits will change in the following ways:

a. The total lifetime amount of benefits your reduced paid-up policy will provide can be determined by multiplying 90% of the lifetime benefit amount at the time the policy becomes paid up by the ratio of the number of months you already paid premiums to the number of months you agreed to pay them.

b. The daily benefit amounts you purchased will also be adjusted by the same ratio.

If you purchased lifetime benefits, only the daily benefit amounts you purchased will be adjusted by the applicable ratio.

Example:

- You bought the policy at age 65 with an annual premium payable for 10 years.

- In the sixth year, you receive a rate increase of 35% and you decide to stop paying premiums.

- Because you have already paid 50% of your total premium payments and that is more than the 40% ratio, your paid-up policy benefits are .45 (.90 times .50) times the total benefit amount that was in effect when you stopped paying your premiums. If you purchased inflation protection, it will not continue to apply to the benefits in the reduced paid-up policy.

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(Source: Amended at 31 Ill. Reg. _____, effective _____)

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Section 2012.EXHIBIT K Replacement and Lapse Reporting Form

Long-Term Care Insurance
Replacement and Lapse Reporting Form

For the State of _____

Reporting Year of _____

Company Name: _____ Due: June 30 annually

Company Address: _____

Company NAIC Number: _____

Contact Person: _____

Phone Number: _____

Instructions

The purpose of this form is to report on a statewide basis information regarding long-term care insurance policy replacements and lapses. Specifically, every insurer shall maintain records for each agent on that agent's amount of long-term care insurance replacement sales as a percent of the agent's total annual sales and the amount of lapses of long-term care insurance policies sold by the agent as a percent of the agent's total annual sales. The tables below should be used to report the 10% of the insurer's agents with the greatest percentages of replacements and lapses.

Listing of the 10% of Agents with the Greatest Percentage of Replacements

Agent's Name	Number of Policies Sold By This Agent	Number of Policies Replaced By This Agent	Number of Replacements As % of Number Sold By This Agent

Listing of the 10% of Agents with the Greatest Percentage of Lapses

Agent's Name	Number of Policies Sold By This Agent	Number of Policies Lapsed By This Agent	Number of Lapses As % of Number Sold By This Agent

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Company Totals:

Percentage of Replacement Policies Sold to Total Annual Sales	_____%
Percentage of Replacement Policies Sold to Policies in Force (as of the end of the preceding calendar year)	_____%
Percentage of Lapsed Policies to Total Annual Sales	_____%
Percentage of Lapsed Policies to Policies in Force (as of the end of the preceding calendar year)	_____%

(Source: Added at 31 Ill. Reg. _____, effective _____)

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1) Heading of the Part: Long-Term Care Partnership Insurance

2) Code Citation: 50 Ill. Adm. Code 2018

3)

Section Numbers:	Proposed Action:
2018.10	Repealed
2018.20	Repealed
2018.30	Repealed
2018.40	Repealed
2018.50	Repealed
2018.60	Repealed
2018.70	Repealed
2018.80	Repealed
2018.90	Repealed
2018.100	Repealed
2018.110	Repealed
2018.120	Repealed
2018.130	Repealed
2018.140	Repealed
2018.150	Repealed
2018.160	Repealed
2018.170	Repealed
2018.180	Repealed
2018.190	Repealed
2018.200	Repealed
2018.210	Repealed
2018.220	Repealed
2018.230	Repealed
2018.EXHIBIT A	Repealed
2018.EXHIBIT B	Repealed
2018.EXHIBIT C	Repealed
2018.EXHIBIT D	Repealed

4) Statutory Authority: Implementing the Partnership for Long-Term Care Act and authorized by Section 45 of that Act [320 ILCS 35]

5) A Complete Description of the Subjects and Issues Involved: With the proposed changes to Part 2012, federal partnership requirements will be included directly in the Long-Term

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Care regulation. The existing Partnership requirements in Part 2018 would actually be in conflict with new federal requirements.

6) Any published studies or reports, along with the sources of underlying data, that were used when comprising this rulemaking: None

7) Will this rulemaking replace any emergency rulemaking currently in effect? No

8) Does this rulemaking contain an automatic repeal date? No

9) Does this rulemaking contain incorporations by reference? No

10) Are there any other proposed rulemakings pending on this Part? No

11) Statement of Statewide Policy Objective: This rulemaking will not require a local government to establish, expand or modify its activities in such a way as to necessitate additional expenditures from local revenues.

12) Time, Place, and Manner in which interested persons may comment on this proposed rulemaking: Persons who wish to comment on this proposed repealer may submit written comments no later than 45 days after the publication of this Notice to:

Eve Blackwell-Lewis, Senior Staff Attorney
Department of Financial and
Professional Regulation
Division of Insurance
320 West Washington, 4th Floor
Springfield, Illinois 62767-0001

217/782-2867

or

Craig Cellini, Rules Coordinator
Department of Financial and
Professional Regulation
320 West Washington
3rd Floor
Springfield, Illinois 62767-0001

217/785-0813

13) Initial Regulatory Flexibility Analysis:

A) Types of small businesses, small municipalities and not for profit corporations affected: None

B) Reporting, bookkeeping or other procedures required for compliance: None

C) Types of professional skills necessary for compliance: None

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14) Regulatory Agenda on which this rulemaking was summarized: January 2007

The full text of the Proposed Repealer begins on the next page:

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TITLE 50: INSURANCE
CHAPTER I: DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION~~INSURANCE~~
SUBCHAPTER z: ACCIDENT AND HEALTH INSURANCE

PART 2018
LONG-TERM CARE PARTNERSHIP INSURANCE (REPEALED)

Section

2018.10 Purpose
2018.20 Applicability and Scope
2018.30 Definitions
2018.40 Policy Definitions
2018.50 Policy Practices and Provisions
2018.60 Unintentional Lapse
2018.70 Required Disclosure Provisions
2018.80 Standards for Marketing
2018.90 Minimum Benefit Standards for Qualifying Policies and Certificates
2018.100 Right to Appeal
2018.110 Required Policy and Certificate Provisions
2018.120 Reporting Requirements
2018.130 Maintaining Auditing Information
2018.140 Reporting on Asset Protection
2018.150 Preparing a Service Summary
2018.160 Plan of Action
2018.170 Auditing and Correcting Deficiencies in Insurer Recordkeeping
2018.180 Loss Ratio
2018.190 Appropriateness of Recommended Purchase
2018.200 Prohibition Against Pre-Existing Conditions and Probationary Periods in Replacement Policies or Certificates
2018.210 Standard Format Outline of Coverage Requirements
2018.220 Requirement to Deliver Shopper's Guide
2018.230 Penalties
2018.EXHIBIT A Class of Insurance - Accident/Health
2018.EXHIBIT B Standard Format - Outline of Coverage
2018.EXHIBIT C Disclosure Statements
2018.EXHIBIT D Long-Term Care Partnership Insurance Suitability Letter

AUTHORITY: Implementing the Partnership for Long-Term Care Act and authorized by Section 45 of that Act [320 ILCS 35].

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SOURCE: Adopted at 18 Ill. Reg 12746, effective August 9, 1994; amended at 19 Ill. Reg. 14809, effective October 6, 1995; amended at 21 Ill. Reg. 14227, effective October 21, 1997; repealed at 31 Ill. Reg. _____, effective _____.

Section 2018.10 Purpose

The purpose of this Part is to implement the Partnership for Long-Term Care Act, to promote the public interest, to promote the availability of long-term care partnership insurance coverage, to protect applicants of long-term care partnership insurance policies from unfair or deceptive sales or enrollment practices, and to facilitate public understanding and comparison of long-term care partnership insurance coverages.

Section 2018.20 Applicability and Scope

Except as otherwise specifically provided, this Part applies to all long-term care partnership policies delivered or issued for delivery in this State by any insurer on or after the effective date of this Part.

Section 2018.30 Definitions

Accelerated Life Product means a life insurance policy or contract which contains benefits providing for the acceleration of life or endowment or annuity benefits in advance of the time they would otherwise be payable as an indemnity for long-term care which is certified or ordered by a physician.

Applicant means, in the case of an individual long-term care partnership policy, the person who seeks to contract for benefits; in the case of a group long-term care insurance policy, the proposed certificateholder.

Asset Protection means the right extended to persons purchasing long-term care partnership policies to retain amounts of assets equal to the sum of qualifying insurance payments made on their behalf in determining eligibility for the Medicaid program. An individual may purchase a certified long-term care partnership insurance policy equal to the amount of assets the individual wishes to protect. For individuals who wish to protect assets equal to or in excess of the cost of four years of long-term care services, a certified long-term care partnership policy with a special feature herein referred to as Total Asset Protection may be purchased. To be eligible for total asset protection, an amount

equal to the average cost of four years of long-term care services in a nursing facility must be purchased. Although a resource has been protected by the long-term care partnership insurance policy, income is to be applied to the cost of care when the insured becomes Medicaid eligible. This protection is extended to the insured during his/her lifetime.

Average Daily Private Pay Rate means the statewide average daily rate charged by nursing facilities for persons not qualifying for federal or state reimbursement, established annually by the Illinois Department of Public Health on a calendar year basis.

Case Management means the assessment of need for services, the development and/or revision of a Plan of Care to meet these needs, implementation and management of the Plan of Care, and monitoring of services delivered pursuant to the Plan of Care.

Case Management Agency means an agency or other entity designated and approved by the Department on Aging and/or the Department of Rehabilitation Services to serve as a Case Coordination Unit (CCU) (89 Ill. Adm. Code 240.260 and 716.200), and which meets criteria established by the insurer. If an agency or entity is not selected by insurers to provide case management service, another CCU shall be selected. If two or more approved agencies offer case management services in the insured's area of residence, the insured may select any of the case management agencies.

Certificate means any certificate issued under a group long-term care partnership policy, which policy has been delivered or issued for delivery in this State.

Cognitive Impairment means confusion or disorientation resulting from a deterioration, limitation and/or loss of functional capacity that is not related to or a result of mental illness but which can result from Alzheimer's disease or related disorders. This impairment is established through use of the Determination Of Need. (Refer to 89 Ill. Adm. Code 240.715 and 685.500.)

Department on Aging (hereafter DonA) means the Illinois Department on Aging.

Department of Insurance (hereafter DOI) means the Illinois Department of Insurance.

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Department of Public Aid (hereafter DPA) means the Illinois Department of Public Aid.

Department of Public Health (hereafter DPH) means the Illinois Department of Public Health.

Department of Rehabilitation Services (hereafter DORS) means the Illinois Department of Rehabilitation Services.

Director means the Director of Insurance.

Eligible Population means persons over the age of 18 years shall be eligible to purchase long-term care partnership policies. Individual insurance carriers may direct policies to all, or a selected subset of this population.

Estate Recovery means that the State of Illinois will have the right to recover from the insured's estate, the equivalent dollar amount of Medicaid costs incurred by the State on the insured's behalf after the long-term care partnership policy benefits were exhausted.

Group Long-Term Care Partnership Policy means a long-term care partnership policy which is delivered or issued for delivery in this State to one of the following:

One or more employers or labor organizations, or a trust or the trustee(s) of a fund established by one or more employers or labor organizations, or a combination thereof, for employees or former employees or a combination thereof, or for members or former members, or a combination thereof, of the labor organizations;

Any professional, trade or occupational association for its members or former or retired members, or combination thereof, if such association:

is composed of individuals all of whom are or were actively engaged in the same profession, trade or occupation; and

has been maintained in good faith for purposes other than obtaining insurance; or

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An association or a trust or the trustee(s) of a fund established, created or maintained for the benefit of members of one or more associations. Prior to advertising, marketing or offering such policy within this State, the association or associations shall file evidence with the Director that the association or associations have at the outset a minimum of 100 members and have been organized and maintained in good faith for purposes other than that of obtaining insurance; have been in active existence for at least one year; and have a constitution and by-laws which provide that:

the association or associations hold regular meetings not less than annually to further the purposes of the members; and

except for credit unions, the association or associations collect dues or solicit contributions from members; and

the members have voting privileges and representation on the governing board and committees.

Thirty days from receipt by the DOI such filing the association or associations will be deemed to satisfy such organizational requirements, unless the Director makes a finding that the association or associations do not satisfy those organizational requirements of this Section.

A group other than those described above shall otherwise be subject to a finding by the Director that:

The issuance of the group policy is not contrary to the best interest of the public;

The issuance of the group policy would result in economies of acquisition or administration;

The benefits are reasonable in relation to the premiums charged;

The standards to be used by the Director for determining whether a group is eligible shall include, but not be limited to: the policy shall not contain broad or misleading exclusions; premiums for group policies are less than premiums for individual policies; and the loss ratio complies with Illinois requirements.

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Health Care Practitioner means:

A chiropractor licensed under the Medical Practice Act of 1987 [225 ILCS 60] to treat human ailments without the use of drugs and without operative surgery.

A dentist licensed under the Illinois Dental Practice Act [225 ILCS 25].

A nurse licensed under the Illinois Nursing Act of 1987 [225 ILCS 65].

An occupational therapist licensed under the Illinois Occupational Therapy Practice Act [225 ILCS 75].

An optometrist licensed under the Illinois Optometric Practice Act of 1987 [225 ILCS 80].

A pharmacist licensed under the Pharmacy Practice Act of 1987 [225 ILCS 85].

A physical therapist licensed under the Illinois Physical Therapy Act [225 ILCS 90].

A physician licensed under the Medical Practice Act of 1987 [225 ILCS 60] to practice medicine in all of its branches.

A podiatrist licensed under the Podiatric Medical Practice Act of 1987 [225 ILCS 100].

A psychologist licensed under the Clinical Psychologist Licensing Act [225 ILCS 15].

A social worker licensed under the Clinical Social Work and Social Work Practice Act [225 ILCS 20].

A speech-language pathologist and/or audiologist licensed under the Illinois Speech-Language Pathology and Audiology Practice Act [225 ILCS 110].

Other Health Care Practitioners licensed by the Illinois Department of Professional Regulation.

A supplier of health care services not described herein, including but not limited to a physician assistant, nurse's aide, or supplier of durable medical equipment.

Insured Event means, for the purposes of determining eligibility for benefits under a qualified policy or certificate, and for determining whether these benefits result in an asset disregard for a qualified insured, the insured shall score fifteen or more points on Part A of the Determination of Need (DON), at least ten of which may be earned on the Mini-Mental State Exam (MMSE). (Refer to 89 Ill. Adm. Code 240.715 and 685.500.)

Insurer means an insurance company, fraternal benefit society, nonprofit health, hospital, or medical service organization, prepaid health plan, health maintenance organization or any similar organization which has delivered or issued for delivery in this State a long-term care partnership policy or certificate.

Long-Term Care Partnership Insurance Policy means any long-term care insurance policy approved as a partnership policy by the Director and issued for delivery to any resident of this State which is designed to provide, within the terms and conditions of the policy, contract or certificate, benefits on an expense-incurred or prepaid basis for necessary care as a result of limited functional capacity in a setting other than an acute care hospital, for at least one (1) year from the date of claim after a considerable elimination period.

Medicaid Eligible Long-Term Care Services include the following:

Long-term care services available under Illinois' State Medicaid plan.

Long-term care services covered under the Medicaid home and community based services waivers for the aged and the disabled and persons with HIV/AIDS.

Other alternate services which are deemed by DPA as essential to prevent institutionalization and offered by licensed or approved providers.

Medicaid Waiver means the home and community based service waivers for the

aged and disabled approved by the United States Department of Health and Human Services Health Care Financing Administration under the provisions of Section 1915(c) of the Social Security Act, which allows Illinois to provide certain community and in-home services not covered in the State Medicaid plan that are instrumental in the avoidance or delay of institutionalization. These services include:

Personal Assistant (PA);

Adult Day Care;

Homemaker;

Maintenance Home Health;

Electronic Home Response Services (EHRS);

Assistive Equipment;

Remodeling;

Respite;

Other home and community based services designed to prevent institutionalization.

Minimum Daily Benefit means the minimum purchase to be offered must be in an amount equivalent to 75% of the average daily private pay rate at the time the policy or certificate is issued.

Policyholder or Certificateholder means a policyholder or certificateholder of a long-term care partnership policy or certificate.

Pre-admission Screening means the program which requires that each person seeking admission to a nursing facility be screened and approved for admission by DoA or DORS or be ineligible for Medicaid reimbursement for a period of 60 days after admission. (Refer to 89 Ill. Adm. Code 240.1010 and 690.100.)

Producer means an insurance producer licensed by DOI who solicits, negotiates,

effects, procures, renews, continues or binds policies of insurance covering property or risks in this State.

Section 2018.40 Policy Definitions

No insurance policy or certificate may be advertised, solicited, delivered or issued for delivery in this State as a long-term care partnership policy unless the policy or certificate contains definitions or terms which are not more restrictive than the requirements of this Section.

"Acute Condition" shall be defined as a condition that causes the individual to be medically unstable. Such individual requires frequent monitoring by medical professionals, such as physicians and registered nurses, in order to maintain his or her health status.

"Adult Day Care" shall be defined as the direct care and supervision of individuals in a community-based setting for the purpose of providing personal attention and promoting social, physical and emotional well-being in a structured setting. Specific components of adult day care service include the following:

Providing and/or arranging of transportation;

Development of a written individualized adult day care Plan of Care; provision of nursing services (e.g., evaluation of the client's needs, routine health monitoring and supervision/administration of medication(s));

Assistance as needed with activities of daily living (e.g., walking, eating, toileting and personal care);

A daily meal meeting one-third of the adult recommended daily dietary allowance with provision for a special diet as directed by the client's physician and supplementary snacks; and

An activity program which includes reality orientation (awareness of time, space, objects and persons), resocialization and stimulation (encourage interaction with others) and supportive counseling (active listening, attention to a client's specific needs and guidance to promote interaction with others).

"Assistive Equipment" shall be defined as tangible personal property with a useful

life of at least one year, expressly designed and used for increasing independent functioning in specific tasks or activities of independent living in the home (e.g., bathing, meal preparation) that directly results in a demonstrated decrease in need for assistance from another individual in performing those tasks or activities (e.g., purchase of bath rails could decrease need for an individual to assist the client with bathing, or purchase of a microwave could reduce the need for an individual to cook for the client).

"Authorized Designee" shall be defined as any person designated in writing to the insurance company by the policyholder or certificateholder of a qualified long-term care partnership policy or certificate for purposes of notification under Section 2018.60 of this Part.

"Chronically Ill Individual" – For all long-term care partnership policies that are marketed as "qualified" pursuant to the Internal Revenue Code of 1986 (26 USCS 7702B), "(t)he term 'chronically ill individual' means any individual who has been certified by a licensed health care practitioner as –

(i) being unable to perform (without substantial assistance from another individual) at least 2 activities of daily living for a period of at least 90 days due to a loss of functional capacity,

(ii) having a level of disability similar (as determined under regulations prescribed by the Secretary in consultation with the Secretary of Health and Human Services) to the level of disability described in clause (i), or

(iii) requiring substantial supervision to protect such individual from threats to health and safety due to severe cognitive impairment.

Such term shall not include any individual otherwise meeting the requirements of the preceding sentence unless within the preceding 12-month period a licensed health care practitioner has certified that such individual meets such requirements." (Quoted from 26 USCS 7702B)

"Electronic Home Response Services" (EHRS) shall be defined as services designed to provide a 24 hour per day emergency communication link to assistance outside the home for individuals so severely disabled that they are incapable of using conventional or modified communication devices such as the telephone, and who have no other persons available in the home should an

emergency arise. EHRS provides a mode by which persons with disabilities who are left alone may signal an Electronic Home Response Center and obtain help. An Electronic Home Response Center is part of a network of emergency responders.

"Elimination Amount" shall be defined as benefits that begin after the insured has accrued qualified long-term care partnership coverage expenses equal to 30, 60, or 90 days of policy benefits.

"Home Health Services" shall be defined as services which may be purchased for individuals at home or other non-institutional residences according to a plan of treatment for illness or infirmity prescribed or recommended by a physician or other health care professional. Home Health Services include three basic subcategories of care:

nursing care including that provided by registered and licensed practical nurses who provide direct acute health care and who also supervise the services of home health aides;

therapy including the services of physical, occupational, and speech therapists; and

home health aide care which includes a wide range of personal convalescent and maintenance health care tasks performed by home health aides under the supervision of nurses.

"Homemaker Service" shall be defined as non-medical support provided by trained and professionally supervised homemakers to maintain, strengthen and safeguard the functioning of individuals in their own homes in accordance with Section 2018.40 of this Part, the authorized Plan of Care. Specific components of homemaker service include the following:

Teaching and/or performing of meal planning and preparation; routine housekeeping skills/tasks (e.g., making and changing beds, dusting, washing dishes, vacuuming, cleaning and waxing floors, keeping the kitchen and bathroom clean and laundering the client's linens and clothing); shopping skills/tasks; and home maintenance and repairs;

Performing and/or assisting with essential shopping and/or errands may

include handling the client's money (proper accounting to the client of money handled and provision of receipts are required) as required by the Plan of Care;

Assisting with self-administered medication which shall be limited to:

reminding the client to take his/her medications;

reading instructions for utilization;

uncapping medication containers; and

providing the proper liquid and utensil with which to take medications;

Assisting with following a written special diet plan and reinforcement of diet maintenance (can only be provided under the direction of a physician and as required by the Plan of Care);

Observing client's functioning and reporting to the appropriate supervisory personnel;

Performing and/or assisting with personal care tasks (e.g., shaving, hair shampooing and combing, bathing and sponge bath, shower bath or tub bath, dressing, brushing and cleaning teeth or dentures and preparation of appropriate supplies, transferring client, and assisting client with range of motion);

Escorting the client to medical facilities, errands, shopping and individual business as specified in the Plan of Care; and

Transportation may be included, to medical facilities, for essential errands/shopping or for essential client business with or in behalf of the client, as specified in the Plan of Care.

"Maintenance Home Health" shall be defined as medically-related services provided in the home in accordance with an ongoing plan of treatment prescribed by a physician. Maintenance Home Health will be provided for long-term, maintenance health care or when shift nursing is necessary. Specific components

of maintenance home health are the following:

Nursing services;

Physical, respiratory, or speech therapy;

The medical/health care services provided by a home health aide.

"Medicare" shall be defined as a program authorized by The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then Constituted or Later Amended (42 USCA 1395 et seq.), including the Medicare Catastrophic Coverage Act of 1988.

"Plan of Care" shall be defined as the specific type and frequency of all services required to maintain the individual in the community, the service providers, and the cost of services. The Plan of Care shall be specified in writing by a state designated case management agency.

"Personal Care" shall be defined as the provision of hands-on services to assist an individual with activities of daily living, such as bathing, eating, dressing, transferring and toileting.

"Personal Assistant (PA) Services" shall be defined as those services performed under the supervision of the client or other person who has agreed to provide such supervision. The PA may:

perform, or assist the client with, household tasks and personal care;

perform incidental health care tasks which do not require independent judgement, with permission of the client's physician, client or family; and/or

perform minimal tasks, such as turning a client in bed during the night or getting the client a glass of water, but primarily involves being available to provide assistance in case of a life or health threatening emergency, such as evacuation in case of fire, moving the client to a safe location in case of tornado, or calling an ambulance if required by a medical emergency.

"Remodeling" shall be defined as modification of a home environment to enable

insureds to be less dependent on direct assistance from others, to help compensate for their loss of agility, strength, mobility or sensation, and to increase their safety or mobility in the home.

"Respite Service" shall be defined as temporary care for insureds aimed at relieving stress for clients' families. Respite Service shall be provided for vacation, rest, errands, family crisis or emergency. Respite Service includes Personal Assistant (PA), Homemaker, Adult Day Care, and Maintenance Home Health (individual or agency) services described in this Section. Respite Service includes a single type of care or a combination of services (e.g., Personal Assistant or Personal Assistant and Homemaker, Personal Assistant and Adult Day Care, Maintenance Home Health and Personal Assistant) based on the client's need.

"Service Summary" shall be defined as a written summary prepared by an insurer for an individual policyholder which identifies the specific precertified policy, the total benefits paid for services rendered to date and the amount qualifying for asset protection.

Section 2018.50 Policy Practices and Provisions

a) Limitations and Exclusions. No policy may be delivered or issued for delivery in this State as a long-term care partnership insurance policy if the policy limits or excludes coverage by type of illness, treatment, medical condition or accident, except as follows:

1) Preexisting conditions or diseases;

2) Mental or nervous disorders, other than Alzheimer's Disease or related disorders;

3) Alcoholism and drug addiction;

4) Illness, treatment or medical condition arising out of:

A) war or act of war (whether declared or undeclared);

B) conviction of a felony, riot or insurrection;

C) service in the armed forces or units auxiliary thereto;

D) suicide (sane or insane), attempted suicide or intentionally self-inflicted injury; or

E) aviation (this exclusion applies only to nonfare paying passengers);

5) Treatment provided in a government facility (unless otherwise required by law), services for which benefits are available under Medicare or other governmental program (except Medicaid), any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law, services provided by the spouse of a covered person and services for which no charge is normally made in the absence of insurance.

b) Case Management. Assessment of need and the development/revision of the Plan of Care shall be provided without a reduction of policy benefits. Case management agencies shall be reimbursed by the State for the administration of the Determination of Need. The insurer shall reimburse the agencies for the development of the Plan of Care and any additional required policy-specific activities related to the determination of eligibility for benefits, as well as any subsequent revisions, as a result of changes in need. If the insured elects to have the case management agency perform service monitoring and Plan of Care implementation and management, the costs of these services shall be part of the policy benefit, reimbursed as a claim, and count towards asset disregard.

c) Extension of Benefits. Termination of long-term care partnership insurance shall be without prejudice to any benefits payable for long-term care partnership services if such services began while the long-term care partnership policy was in force and continues without interruption after termination. Such extension of benefits beyond the period the long-term care partnership policy was in force may be limited to payment of the maximum benefits and may be subject to any policy waiting period and all other applicable provisions of the policy.

d) Continuation or Conversion.

1) Group long-term care partnership policies issued in this State shall provide covered individuals with a basis for continuation or conversion of coverage.

A) A basis for continuation of coverage means a policy provision which maintains coverage under the existing group policy when such coverage would otherwise terminate and which is subject only to the continued timely payment of premium when due;

B) A basis for conversion of coverage means a policy provision that an individual whose coverage under the group policy would otherwise terminate or has been terminated for any reason, including discontinuance of the group policy in its entirety or with respect to an insured class, and who has been continuously insured under the group policy (and any group policy which it replaced), for at least 6 months immediately prior to termination, shall be entitled to the issuance of a converted policy by the insurer under whose group policy the individual is covered, without evidence of insurability.

2) Converted policy means an individual long-term care partnership policy providing benefits identical to or substantially equivalent to or in excess of those provided under the group policy from which conversion is made.

3) Written application for the converted policy shall be made and the first premium due, if any, shall be paid as directed by the insurer not later than 31 days after termination of coverage under the group policy. The converted policy shall be issued effective on the day following the termination of coverage under the group policy and shall be guaranteed renewable.

4) Unless the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy from which conversion is made. Where the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy replaced.

5) Continuation of coverage or issuance of a converted policy shall be mandatory, except where:

A) Termination of group coverage resulted from an individual's failure to make any required payment of premium or contribution when due; or

B) The terminating coverage is replaced not later than 31 days after termination, by group coverage effective on the day following the termination of coverage:

i) Providing benefits identical to or benefits equivalent in design and actuarially equivalent in value in excess of those provided by the terminating coverage; and

ii) The premium for which is calculated in a manner consistent with the requirements of subsection (d)(4) of this Section.

6) Notwithstanding any other provision of this subsection, any insured individual whose eligibility for group long-term care partnership coverage is based upon his or her relationship to another person shall be entitled to continuation of coverage under the group policy upon termination of the qualifying relationship by death or dissolution of marriage.

e) Discontinuance and Replacement.
If a group long-term care partnership policy is replaced by another group long-term care partnership policy issued to the same policyholder, the succeeding insurer shall offer coverage to all persons covered under the previous group policy on its date of termination. Coverage provided or offered to individuals by the insurer and premiums charged to persons under the new group policy:

1) Shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced; and

2) Shall not vary or otherwise depend on the individual's health or disability status, claim experience or use of long-term care services.

f) Termination of Long-Term Care Partnership Insurance Policy Program Participation.

Insurers shall make available to the insureds the opportunity to purchase any traditional long-term care policy offered by the insurer which has benefits

comparable to the benefits provided by a certified long-term care insurance policy. The insurer shall make these policies available without requiring evidence of insurability in the event of the termination of the program.

g) The premiums charged to an insured for long-term care insurance shall not increase due to either:

1) The increasing age of the insured; or

2) The duration the insured has been covered under the policy.

h) No long-term care partnership policy shall:

1) Be cancelled, nonrenewed or otherwise terminated on grounds of the age or deterioration of the mental or physical health of the insured individual or certificateholder; or

2) Contain a provision establishing a new waiting period in the event existing coverage is converted to, or replaced by a new or other form within the same company, except with respect to an increase in benefits voluntarily selected by the insured individual or group certificateholder.

Section 2018.60 Unintentional Lapse

Each insurer offering long-term care partnership insurance shall, as a protection against unintentional lapse, comply with the following:

a) Notice before lapse or termination.

1) No individual long-term care partnership policy or certificate shall be issued until the insurer has received from the applicant a written designation of at least one person, in addition to the applicant, who is to receive notice of lapse or termination of the policy or certificate for nonpayment of premium, or a written waiver dated and signed by the applicant electing not to designate additional persons to receive notice. The applicant has the right to designate at least one person who is to receive the notice of termination, in addition to the insured. Designation shall not constitute acceptance of any liability on the third party for services provided to the insured. The form used for the written

designation shall provide space designated for listing at least one person. The designation shall include each person's full name and home address. In the case of an applicant who elects not to designate an additional person, the waiver shall state: "Protection against unintended lapse. I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long-term care insurance policy for nonpayment of premium. I understand that notice will not be given until at least ten (10) days after a premium is due and unpaid. I elect NOT to designate any person to receive such notice." The insurer shall also notify the insured of the right to designate or change the designee, no less often than once every 2 years.

2) When the policyholder or certificateholder pays the premium for a long-term care partnership policy or certificate through a payroll or pension deduction plan, the requirements contained in subsection (a)(1) of this Section need not be met until sixty (60) days after the policyholder or certificateholder is no longer on such a payment plan. The application or enrollment form for such policies or certificates shall indicate the payment plan selected by the applicant.

3) Lapse or termination for nonpayment of premium. No individual long-term care partnership policy or certificate shall be terminated for nonpayment of premium unless the insurer, not less than ten (10) days following the premium due date, has given notice to the insured and to those persons designated pursuant to subsection (a)(1) of this Section, at the address provided by the insured for purposes of receiving notice of lapse or termination. Notice shall be given by first class United States mail, postage prepaid. Notice shall be deemed to have been given as of five (5) days after the date of mailing.

b) In addition to the requirements of subsection (a) above, a long-term care partnership policy or certificate shall include a provision which provides for reinstatement of coverage, in the event of lapse, if the insurer is provided proof of cognitive impairment as defined in Section 2018.30(m) of this Part and as determined by a physician. This option shall be available to the insured for no less than (5) months after termination and shall allow for the collection of past due premium.

Section 2018.70 Required Disclosure Provisions

a) Renewability. Individual long-term care partnership policies shall contain a renewability provision. Such provision shall be captioned as a Renewal, shall appear on the first page of the policy, and shall clearly state the duration, where limited, of renewability and the duration of the term of coverage for which the policy is issued and of which it may be renewed.

b) Riders and Endorsements. Except for riders or endorsements by which the insurer effectuates a request made in writing by the insured under an individual long-term care partnership policy, all riders or endorsements added to an individual long-term care insurance policy after issuance or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the individual insured. After issuance, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term shall be agreed to in writing and signed by the insured, with the exception of when the increased benefits or coverage are required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, such premium charge shall be set forth in the policy, rider or endorsement.

c) Pre-existing Conditions. If a long-term care partnership policy or certificate contains any limitations with respect to pre-existing conditions, such limitations shall appear as a separate paragraph of the policy or certificate and shall be labeled "Pre-existing Condition Limitations". Limitations to pre-existing conditions shall be in accordance with Section 351A-5 of the Illinois Insurance Code [215 ILCS 5/351A-5].

d) Disclosure Requirements for Accelerated Life Products.

1) Policy Summary
At the time of policy delivery, a policy summary shall be delivered for an individual life insurance policy which provides long-term care partnership benefits within the policy or by rider. In the case of direct response solicitations, the insurer shall deliver the policy summary upon the applicant's request, but regardless of request shall make such delivery no later than at the time of policy delivery. In addition to complying with all applicable requirements, the summary shall also include:

A) an explanation of how the long-term care partnership benefit

interacts with other components of the policy, including deductions from death benefits;

B) an illustration of the amount of benefits, the length of benefit, and the guaranteed lifetime benefits, if any, for each covered person;

C) any exclusions, reductions and limitations on long-term care partnership benefits; and

D) if applicable to the policy type, the summary shall also include:

i) disclosure of the effects of exercising other rights under the policy;

ii) disclosure of guarantees related to long-term care partnership benefit costs of insurance charges; and

iii) current and projected maximum lifetime benefits.

2) Benefit Reports
Any time a long-term care partnership benefit funded through a life insurance vehicle by the acceleration of the death benefit is in benefit payment status, a monthly report shall be provided to the policyholder. Such report shall include:

A) any long-term care partnership benefits paid during the month;

B) an explanation of any changes in the policy, including changes in death benefits or cash values, due to long-term care partnership benefits being paid out; and

C) the amount of long-term care partnership benefits existing or remaining.

3) Outline of Coverage
The Outline of Coverage should include an example filled out in John Doe form which illustrates how the long-term care partnership policy benefits are calculated. Refer to Section 2012.110 and Exhibit B for format and content requirements.

e) An applicant and/or policyholder shall be given a copy of an explanation of the Right to Appeal found in Section 2018.100 of this Part, during the initial visit with an insurance producer, or upon request.

f) In order to distinguish policies that provide for total asset protection for the individual policyholder, the following statement shall be included on the cover of each individual policy, as well as in the outline of coverage:

> At the date of purchase this policy provides coverage which is equal to, or greater than, the average cost of four years of long term care services in a nursing facility.

Section 2018.80 Standards for Marketing

No long-term care partnership policy or certificate shall be advertised, solicited, or issued for delivery in this State as a long-term care partnership policy or certificate unless it has been approved by the Director. Each insurer seeking approval of a long-term care partnership policy or certificate shall:

a) Provide the DOI with a written summary of the methods the insurer will use to alert the consumer, prior to presentation of an application for long-term care partnership insurance, of the availability of consumer information and public education provided by the Senior Health Insurance Program (SHIP) of the DOI.

b) Utilize applications to be signed by the applicant which indicate that the applicant:

1) Received a complete description of the Illinois long-term care partnership program entitled "What You Should Know About The Long-Term Care Partnership" available from any of the participating agencies, which includes an explanation of asset protection and how it is achieved. In addition to these, an address and a toll free consumer information telephone number for SHIP shall be provided, as 1-800-548-9034, located at Department of Insurance, 320 W. Washington, 4th Floor, Springfield, Illinois 62767.

2) Received a description of the insurer's long-term care partnership policy or certificate benefit option.

3) Agrees to the release of information by the insurer to the State as may be needed to evaluate the Illinois long-term care partnership program, and document a claim for Medicaid asset protection in the following format:

"CONSENT AND AUTHORIZATION
TO RELEASE INFORMATION

I hereby agree to the release of all records and information pertaining to this long-term care partnership policy or certificate by the [insert issuer name] to the State of Illinois for the purpose of documenting a claim for Asset Protection under the State Medicaid program, for evaluating the Illinois Long-Term Care Partnership Program, and for meeting Medicaid or Department of Insurance audit requirements.

I understand that the information contained in these records will be used for no purpose other than those stated above, and will be kept strictly confidential by the State of Illinois.

_____
(Signature of Applicant(s)."

4) Received a description regarding mandatory inflation protection that shall be in the following format:

"NOTICE TO APPLICANT REGARDING
MANDATORY INFLATION PROTECTION

All Long-Term Care Partnership policies provide for automatic increases in daily coverage benefits of at least 5% per year compounded. Companies may offer greater inflation protection. Depending on the option you choose to automatically inflate daily coverage benefits, premiums may rise over the life of the policy [certificate]. [Insert insurer name] will provide you with a graphic comparison showing the differences between a policy inflating at 5% and a policy inflating at a greater percentage, over at least a twenty (20) year period."

c) Report to the DOI all sales involving replacement of existing policies and

certificates by long-term care partnership policies or certificates quarterly to include:

1) The name and address of the insured.

2) The name of the company whose policy or certificate is being replaced.

3) The name of the producer replacing the coverage.

4) A comparison of the coverage issued with that being replaced, including a comparison of premiums and an explanation of how the replacement was beneficial to the insured. The replacing insurer shall not cancel, nonrenew, or rescind a replacement long-term care partnership policy or certificate for any reason other than nonpayment of premium, material misrepresentation, or fraud.

d) Provide producer training as follows:

1) Certify by letter to the Department of Insurance that procedures are in place to assure that no producer will be authorized to market, sell, solicit, or otherwise contact any person for the purpose of marketing a long-term care partnership policy or certificate unless the producer has completed six (6) hours of training on traditional long-term care insurance, specifically titled "Traditional Long-Term Care Insurance Policy", as prescribed in Exhibit E (50 Ill. Adm. Code 2012) and complete an additional six (6) hours of training on the Illinois long-term care partnership insurance as specifically titled "Long-Term Care Partnership Policy", as prescribed in Exhibit A of this Part. These courses cannot be included as a part of any other certified continuing education course; however these courses may satisfy a part of the continuing education requirements of Section 494.1(c) of the Illinois Insurance Code [215 ILCS 5/494.1(c)]. Insurers and producers shall maintain evidence of completion of the hours of training required and shall provide proof of completion upon request. Such proofs of completion shall be in the format prescribed by 50 Ill. Adm. Code 3119.Exhibit D, and shall be signed by the producer and the provider of the education attesting to the completion of required training. The course of study content requirements appearing in Exhibit A shall be satisfied.

2) The required training hours referenced in subsection (d)(1) of this Section

may qualify as part of the continuing education requirements of Section 494.1(c) of the Illinois Insurance Code [215 ILCS 5/494.1(c)] only if the training course has been certified under 50 Ill. Adm. Code 3119.30. Each educational provider shall submit its request for certification to the Director on a form prescribed by 50 Ill. Adm. Code 3119.Exhibit B at least 30 days prior to any course being offered. All educational providers and training courses qualifying for continuing education credit shall be renewed on an annual basis.

e) Include a statement on the outline of coverage, the policy or certificate application, and the front page of the long-term care partnership policy or certificate in bold type and in a separate box as follows: "THIS POLICY [CERTIFICATE] IS APPROVED UNDER THE ILLINOIS LONG-TERM CARE PARTNERSHIP INSURANCE PROGRAM."

f) Long-term care insurance policies or certificates sold after July 1, 1994, that are not under the Illinois long-term care partnership program must include a statement on the outline of coverage, the policy or certificate application, and the front page of the policy or certificate in bold type and in a separate box as follows: "THIS POLICY [CERTIFICATE] IS NOT APPROVED FOR MEDICAID ASSET PROTECTION UNDER THE ILLINOIS LONG-TERM CARE PARTNERSHIP PROGRAM. HOWEVER, THIS POLICY [CERTIFICATE] IS AN APPROVED LONG-TERM CARE POLICY [CERTIFICATE] UNDER STATE INSURANCE REGULATIONS. FOR INFORMATION ABOUT POLICIES AND CERTIFICATES APPROVED UNDER THE ILLINOIS LONG-TERM CARE PARTNERSHIP PROGRAM, CALL THE SENIOR HELPLINE AT THE DEPARTMENT ON AGING AT 1-800-252-8966."

g) Provide that no long-term care partnership policy or certificate shall be sold, transferred, or otherwise ceded to another insurer without first having obtained approval from the Director.

h) Except as provided below, an insurer shall continue to make available for purchase any policy or certificate issued that has been approved by the Director. The following describes the process and result of discontinuing the availability of a policy or certificate:

1) An insurer may discontinue the availability of a policy or certificate if the

insurer provides the Director, in writing, its decision at least thirty (30) days prior to discontinuing the availability of the policy or certificate. The following shall be considered a discontinuance of the availability of a policy or certificate:

A) The sale or other transfer of a policy or certificate to another insurer.

B) A change in the rating structure or methodology unless the insurer complies with the following requirements:

The insurer shall provide an actuarial memorandum which contains a complete description of the current rating methodology including all assumptions underlying the current rates, and a complete description of the revised rating methodology including all assumptions underlying the rates proposed under the revised rating methodology, and actuarial justification, i.e., experience studies, general population data, etc., for each of the assumptions that are different than the corresponding assumptions underlying the current rates, and a demonstration of actuarial relationship between the current and proposed rates using the distribution of current insureds, and an identification of the rating cells, i.e., age, sex, etc., which experience the greatest change in rates due to the change in rating methodology, and a demonstration that the rates based on the new rating methodology meet the loss ratio requirements of this Part and any other relevant information. The actuarial memorandum should identify the actuary responsible for establishing the change in rating methodology and be signed by the actuary.

2) An insurer that discontinues the availability of a policy or certificate under subsection (1) above shall not file for approval of a new long-term care partnership policy or certificate for a period of five (5) years after the insurer provides notice to the Director of the discontinuance.

Section 2018.90 Minimum Benefit Standards for Qualifying Policies and Certificates

DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

NOTICE OF PROPOSED REPEALER

No long-term care partnership policy or certificate shall be advertised, solicited, or issued for delivery in this State as a long-term care partnership policy or certificate which does not meet the minimum benefit standards of this Section, and which has not been approved by the Director. These minimum standards do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards. These standards are in addition to all other requirements of this Part. In order to participate in the Illinois long-term care partnership program, a policy or certificate shall meet the following:

a) Contain a minimum daily benefit amount as defined in Section 2018.30.

b) Provide that benefits be available in dollars, and not in days of care.

c) When an individual purchases a certified long-term care partnership insurance policy, the issuer must notify the purchaser of the benefits of purchasing inflation protection for the long-term care partnership insurance policy.

d) Provide the following upon the initial effective date:

1) A daily nursing facility benefit of at least 75% of the average daily private pay rate in nursing facilities rounded to the next highest $5 increment.

2) A home and community based benefit of at least 50% of the monthly nursing facility benefit contained in the long-term care partnership policy or certificate. The monthly home and community based benefit shall not exceed the monthly nursing facility benefit.

e) No policy or certificate shall pay benefits in excess of the actual charges.

f) Payment for nursing facility services and home care is the lesser of the contracted insurance benefit or the actual charge.

g) Provide an explanation of Asset Protection as defined in Section 2018.30.

h) Provide an explanation of Estate Recovery as defined in Section 2018.30.

Section 2018.100 Right to Appeal

a) All appeals shall be reviewed by DonA and referred to the appropriate participating State agency for processing when necessary.

b) An individual who applies for or receives coverage under any long-term care partnership policy has the right to appeal the following:

1) Denial of coverage to DonA and DOI.

2) Denial of benefits to DonA, DOI and DORS.

3) The Plan of Care to DonA and DORS.

c) An applicant, policyholder or certificateholder shall be given a copy of an explanation of the right to appeal during the initial visit with an insurance producer or upon request.

Section 2018.110 Required Policy and Certificate Provisions

All long-term care partnership policies and certificates shall meet the following requirements:

a) Charge premiums based on the issue age of the applicant at the time of policy or certificate issuance, not the attained age of the insured.

b) Include a provision that the long-term care policy or certificate shall utilize the insured event criteria, defined in Section 2018.30 of this Part, for determining eligibility for benefits and for determining the amount of asset disregard. Approval for admission to a nursing facility under the Illinois preadmission screening program shall be deemed sufficient, but not necessary to meet this insured event criteria.

c) Include a provision that the long-term care partnership policy or certificate benefits can be used to purchase nursing facility care or home and community based care. Home and community based care shall include those services listed in Section 2018.30 of this Part.

d) Include a provision that the insurer will provide to the insured reports of asset protection as defined in Section 2018.140 of this Part, and service summaries as defined in Section 2018.150 of this Part to enable the insured to establish the amount of Asset Disregard.

e) Include a provision which allows for a thirty (30) day period within which

coverage may be cancelled by the insured by delivering or mailing the evidence of coverage to the insurer or the producer through whom it was effected for a full refund of any premium that was paid. The long-term care partnership policy or certificate shall have a notice prominently printed on the first page of the policy or certificate, or attached thereto, stating that the policyholder or certificateholder shall have the right to return the policy or certificate to the insurer or its producer for cancellation within thirty (30) days after its delivery and to have the premium refunded if, after examination of the long-term care partnership policy or certificate, the insured person is not satisfied for any reason.

f) Include a provision which, in the event the policy or certificate is about to lapse or the policy or certificate is about to lose qualification status under Section 2018.30 of this Part, offers the long-term care partnership policyholder or certificateholder the option to reduce coverage to a lower benefit amount. However, this benefit amount offer, plus the amount of benefits used to date, shall not be less than the minimum benefit amount requirement specified in Section 2018.30 of this Part. The insurer need only allow this offer to be exercised one (1) time. Premiums shall be based on the age of the long-term care partnership policyholder or certificateholder at the time of the issuance of the original policy or certificate.

g) Include a provision that, upon sale of a long-term care partnership policy or certificate, the insurer shall do the following:

1) Offer to collect and maintain the name and address of an individual designated as an authorized designee, by the purchaser, to be notified when a policy or certificate lapse is imminent. The insurer shall obtain a signed statement from purchasers who do not choose to exercise their right to designate an authorized designee. Such statement shall also include that the purchaser(s) have been offered this opportunity and declined. It shall be the insurer's responsibility to notify such designee prior to canceling a long-term care partnership policy or certificate due to lack of premium payment. The designee notification shall occur no later than thirty (30) days after a premium is due and unpaid. The insurer shall permit the long-term care partnership policyholder or certificateholder to no less often than once every 2 years update the authorized designee.

2) Allow for the insured to request, within 5 months after termination, reinstatement of the long-term care partnership policy or certificate when such policy or certificate has lapsed due to nonpayment of premium, when

the insured has a cognitive impairment and has paid all due and unpaid premiums. The reinstated long-term care partnership policy or certificate shall have the same benefits, terms, and premiums as the policy or certificate which lapsed.

h) Include a provision that benefits shall only be paid after the payment of all other benefits to which the long-term care partnership policyholder or certificateholder is otherwise entitled, excluding Medicaid. The insurer shall make efforts to determine whether benefits are available from other long-term care partnership policies or certificates or from Medicare.

i) Include a provision that the policy form shall not be changed or otherwise modified without the signed acceptance of the policyholder, or include a provision that the certificate issued under a group long-term care partnership policy shall not be changed or otherwise modified without the signed acceptance of the certificateholder.

j) Include a provision that the benefits shall be determined and established by the Case Management Agency through the development of an authorized Plan of Care.

Section 2018.120 Reporting Requirements

The requirements of this Section refer to insurer documentation and reporting requirements for long-term care partnership policies and certificates. The reports shall be submitted for each person entitled to benefits under a long-term care partnership policy or certificate. The report shall conform with the Long-Term Care Insurance Uniform Data Set (February 15, 1993, revised November 30, 1993) established for Robert Wood Johnson Foundation Projects in a manner and form prescribed by the DOI. Insurers may receive a copy of the data set upon request to the DOI, at a charge.

Section 2018.130 Maintaining Auditing Information

a) Every insurer shall maintain information as required by subsection (f) below, on all long-term care partnership policyholders or certificateholders who have ever received any benefit under the policy or certificate. Such information shall be updated at least quarterly. This requirement for updating shall not require the conduct of any assessment, reassessment, or other evaluation of the long-term care partnership policyholder's or certificateholder's condition which is not

otherwise required.

b) When a long-term care partnership policyholder or certificateholder who has received any benefit dies or lapses a long-term care partnership policy or certificate for any reason, the insurer shall retain the required information for a period of at least five (5) years after the time when the policy was in force. Unless notified by the DOI to the contrary during this period, after the expiration of five (5) years, the service summary provided by the insurer will be deemed to comply with all asset protection reporting, record keeping, and auditing requirements of this Part. The insurer may use microfiche, microfilm, optical storage media, or any other cost effective method of record storage as alternatives to storage of paper copies.

c) At the time the long-term care partnership policy or certificate ceases to be in force, the insurer shall notify the policyholder or certificateholder of the right to request a copy of the service records as required by subsection (f) below.

d) The insurer shall also, upon request in writing, provide such policyholder or certificateholder or the policyholder's or certificateholder's authorized designee, if any, with a copy of the insurer's service records as required by subsection (f) below which are necessary to establish the asset disregard. These records shall be provided within sixty (60) days after a request.

e) The insurer shall enclose with the records a statement advising former long-term care partnership policyholders or certificateholders that it is in their best interest to retain the records if they ever wish to establish eligibility for Medicaid.

f) The information to be maintained includes the following:

1) Evidence that the insured event has taken place. The occurrence of the insured event shall be documented by case management agency staff, as part of the initial assessment of the client or as part of a subsequent reassessment.

2) Description of services provided under the long-term care partnership policy or certificate, including the following:

A) Name, address, phone number, and professional license number, if applicable, of Provider.

B) Amount, date, and type of services provided, and whether the services qualify for asset protection.

C) Dollar amounts paid by the insurer.

D) The charges of the service providers, including copies of all invoices for services counting toward asset protection.

E) Identification of the case management agency, if applicable, and copies of all assessments and reassessments.

F) Determination of whether the long-term care partnership policyholder or certificateholder was a qualified insured at the time of benefit payment. The insurer may rely on written representation by the long-term care partnership policyholder or certificateholder as to whether he or she has had the required coverages defined in this Part.

3) In order for home and community based services to qualify for asset protection, these services shall be in accord with a Plan of Care developed by a case management agency. If the long-term care partnership policyholder or certificateholder has received any benefits delivered as part of a Plan of Care, the insurer shall retain the following:

A) A copy of the original Plan of Care and the Determination of Need.

B) A copy of the Plan of Care required by DoA or DORS.

C) A copy of any changes made in the Plan of Care. The Plan of Care shall document that the changes are required by changes in the client's medical situation, cognitive abilities, or the availability of social supports. Such services shall count towards asset protection after the case management agency adds the documented need for and description of the new services to the Plan of Care.

Section 2018.140 Reporting on Asset Protection

a) Every insurer shall send an asset protection report at least quarterly to each long-

term care partnership policyholder or certificateholder who has received any benefits since the last asset protection report. Each asset protection report shall include the following information:

1) The amount of asset protection for which the long-term care partnership policyholder or certificateholder had qualified prior to the quarter covered by the current report.

2) The total benefits paid by the insurer for services rendered during the current quarter.

3) A statement of the amount of benefits paid by the insurer for services rendered during the current quarter which qualify for asset protection.

4) A summary total of the amount paid to date under the long-term care partnership policy or certificate which qualifies for asset protection.

b) Asset protection reports shall be subject to audit by the Director.

Section 2018.150 Preparing a Service Summary

a) Every insurer shall prepare a service summary at the insured's request specifically for the policyholder or certificateholder applying for Medicaid. The insurer shall also prepare a service summary when the policyholder or certificateholder has exhausted benefits under the long-term care partnership policy or certificate or when the policy or certificate ceases to be in force for a reason other than the death of the policyholder or certificateholder, whichever occurs first.

b) This Service Summary is separate and in addition to the information requirements of Section 2018.130. The service summary shall identify the following:

1) The specific long-term care partnership policy or certificate.

2) The total benefits paid for services rendered to date.

3) The amount qualifying for asset protection.

c) A copy of the service summary shall be sent to the DPA 30 days before the exhaustion of the benefits.

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Section 2018.160 Plan of Action

Every insurer shall submit to the DOI a plan for complying with the information maintenance and documentation requirements set forth in this Part. The documentation plan shall include the following:

a) The location where records will be kept. Records required for purposes of the Illinois long-term care partnership program shall be available at no more than three (3) locations, each of which shall be easily accessible to the Department of Insurance.

b) The insurer shall agree to give the Director, or his/her appointed designee, access to all information described in this Part on an aggregate basis for all long-term care partnership policyholders or certificateholders and on an individual basis for all policyholders or certificateholders who have ever received any benefits. Access to information on persons who have not applied for Medicaid is required in order for the Director, or his or her appointed designee, to determine if an insurer's system for documenting asset protection is functioning correctly. The Director shall have the final decision concerning the frequency of access to the data and the size of samples for auditing or other purposes.

c) The name, job title, address, and telephone number of the person primarily responsible for the maintenance of the information required and for acting as liaison with DPA and the DOI covering the information.

d) Methods for determining when insurance benefits or prepaid benefits qualify for asset protection shall include the following:

1) Documentation of the insured event.

2) Description of services.

3) Documentation of charges and benefits paid.

4) Documentation of plans of care, when required.

e) Description of electronic and manual systems which will be used in maintaining the required information.

f) Information that will be retained which is needed to comply with this Part.

g) Copies of forms and descriptions of standard procedures for maintaining and reporting the information required, including the specific electronic medium which will be used to report required information and a description of the relevant files.

Section 2018.170 Auditing and Correcting Deficiencies in Insurer Recordkeeping

The Director shall consult with DPA for all audits and examinations that may be required to determine compliance with this Section.

Section 2018.180 Loss Ratio

Benefits under group and individual direct response and individual long-term care partnership policies shall be deemed reasonable in relation to premiums provided the lifetime anticipated loss ratio is at least sixty percent (60%), calculated on the basis of the ratio of the present value of the expected benefits to the present value of the expected premiums over the entire period for which rates are computed to provide coverage. In evaluating the lifetime anticipated loss ratio, consideration shall be given to the following factors:

a) Statistical credibility of incurred claims experience based on the following factors: claim rates, variability in transaction costs, and number of lives exposed;

b) The period for which rates are computed to provide coverage;

c) Experienced and projected trends;

d) Concentration of experience within early policy duration;

e) Expected claim fluctuation;

f) Experience refunds, adjustments or dividends;

g) Renewability features;

h) Interest;

i) Experimental nature of the coverage;

j) Product features such as long elimination periods (period between when the claim arises and insured is eligible to receive benefits), high deductibles and high maximum limits.

Section 2018.190 Appropriateness of Recommended Purchase

In recommending the purchase or replacement of any long-term care partnership policy or certificate, an insurance producer shall make efforts to determine the appropriateness of a recommended purchase or replacement, and the self-assessment guide available from DonA or DOI shall be provided.

Section 2018.200 Prohibition Against Pre-Existing Conditions and Probationary Periods in Replacement Policies or Certificates

If a long-term care partnership policy or certificate replaces another long-term care partnership policy or certificate, the replacing insurer shall waive any time periods applicable to pre-existing conditions and probationary periods in the new long-term care partnership policy for similar benefits to the extent that exclusions have been satisfied under the original partnership policy.

Section 2018.210 Standard Format Outline of Coverage Requirements

This Section implements, interprets and makes specific the provisions of Section 351A-8 of the Illinois Insurance Code [215 ILCS 5/351A-8] in prescribing a standard format and the content of an outline of coverage.

a) The outline of coverage shall be a free-standing document, using no smaller than ten point type.

b) The outline of coverage shall contain only the provisions found within the policy itself.

c) Text which is capitalized or underscored in the standard format outline of coverage may be emphasized by other means which provide prominence equivalent to such capitalization or underscoring.

d) Use of the text and sequence of text of the standard format outline of coverage is mandatory.

e) The standard format, including style, arrangement and overall appearance, and the content of an outline of coverage appears in Exhibit B.

Section 2018.220 Requirement to Deliver Shopper's Guide

A long-term care partnership insurance shopper's guide shall be provided to all prospective applicants of a long-term care partnership policy or certificate.

Section 2018.230 Penalties

Pursuant to Section 351A-11 of the Illinois Insurance Code [215 ILCS 5/351A-11], an insurer or insurance producer who is found to have violated any requirement of this State relating to the regulation of long-term care partnership policies or certificates, or the marketing of such insurance, shall be subject to a fine of up to three (3) times the amount of any commissions paid for each policy involved in the violation, or up to $10,000, whichever is greater.

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Section 2018.EXHIBIT A Class of Insurance – Accident/Health

Course of Study Content Requirements for Long-Term Care Partnership Policies:

a) Traditional Long-Term Care Policies vs. Long-Term Care Partnership Policies

b) Policy Provisions, Options and Benefits

c) Long-Term Care Range of Services

d) Nursing home care levels, costs, options and nursing home prescreening

e) Medicaid eligibility and long-term care

f) Medicaid regulations on spend down and asset transfer

g) Estate recovery by Department of Public Aid

h) Suitability of long-term partnership policy considering amount of assets owned

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Section 2018.EXHIBIT B Standard Format - Outline of Coverage

[COMPANY NAME]
[ADDRESS – CITY & STATE]
[TELEPHONE NUMBER]
LONG-TERM CARE PARTNERSHIP INSURANCE
OUTLINE OF COVERAGE

[Policy Number or Group Master Policy and Certificate Number]

1. This policy is [an individual policy of insurance] ([a group policy] which was issued in the [indicate jurisdiction in which group policy was issued]).

2. PURPOSE OF OUTLINE OF COVERAGE. This outline of coverage provides a very brief description of the important features of the policy. You should compare this outline of coverage to outlines of coverage for other policies available to you. This is not an insurance contract, but only a summary of coverage. Only the individual or group policy contains governing contractual provisions. This means that the policy or group policy sets forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you READ YOUR POLICY [OR CERTIFICATE] CAREFULLY!

3. TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE CONTINUED IN FORCE OR DISCONTINUED.

   a) For long-term care partnership policies or certificates, include the following permissible policy renewability provisions: Policies and certificates that are guaranteed renewable shall contain the following statement: RENEWABILITY: THIS POLICY [CERTIFICATE] IS GUARANTEED RENEWABLE. This means you have the right, subject to the terms of your policy [certificate], to continue this policy as long as you pay your premiums on time. [Company Name] cannot change any of the terms of your policy on its own, except that, in the future, IT MAY INCREASE THE PREMIUM YOU PAY.

   b) For group coverage, specifically include continuation/conversion provisions applicable to the certificate and group policy;

   c) Include waiver of premium provisions or state that there are no such provisions;

d) State whether the company has a right to change premium, and if such right exists, include each circumstance under which premium may change.

4. TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE RETURNED AND PREMIUM REFUNDED. [Provide a brief description of the right to return – "free look" provision of the policy.]

5. THIS IS NOT MEDICARE SUPPLEMENT COVERAGE. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the insurance company.
[For agents] Neither [insert company name] nor its agents represent Medicare, the federal government or any state government.

6. LONG-TERM CARE PARTNERSHIP COVERAGE. Policies of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital, such as in a nursing home, in the community or in the home.

7. BENEFITS PROVIDED BY THIS POLICY.

a) Covered services, related deductible(s), waiting periods, elimination periods and benefit maximums.

b) Institutional benefits, by skill level.

c) Non-institutional benefits, by skill level.

[Any benefit screens must be explained in this Section. If these screens differ for different benefits, explanation of the screen should accompany each benefit description. If an attending physician or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, this too must be specified. If activities of daily living (ADLs) are used to measure an insured's need for long-term care, then these qualifying criteria or screens must be explained.]

8. LIMITATIONS AND EXCLUSIONS.
Describe:

a) Preexisting conditions;

b) Non-eligible facilities/provider;

c) Non-eligible levels of care (e.g., unlicensed providers, care or treatment provided by a family member, etc.);

d) Exclusions/exceptions;

e) Limitations.

[This Section should provide a brief specific description of any policy provisions which limit, exclude, restrict, reduce, delay, or in any other manner operate to qualify payment of the benefits described in (6) above.]

9. RELATIONSHIP OF COST OF CARE AND BENEFITS.
Because the costs of long-term care services will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted. [As applicable, indicate the following:

a) That the benefit level will **not** increase over time;

b) Any automatic benefit adjustment provisions;

c) Whether the insured will be guaranteed the option to buy additional benefits and the basis upon which benefits will be increased over time if not by a specified amount or percentage;

d) If there is such a guarantee, include whether additional underwriting or health screening will be required, the frequency and amounts of the upgrade options, and any significant restrictions or limitations;

e) And finally, describe whether there will be any additional premium charge imposed, and how that is to be calculated.]

10. ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS.
State that the policy provides coverage for insureds clinically diagnosed as having Alzheimer's disease or related degenerative and dementing illnesses. Specifically describe each benefit screen or other policy provision which provides preconditions to the availability of policy benefits for such an insured.

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11. PREMIUM.

a) State the total annual premium for the policy;

b) If the premium varies with an applicant's choice among benefit options, indicate the portion of annual premium which corresponds to each benefit option.

12. ADDITIONAL FEATURES.

a) Indicate if medical underwriting is used;

b) Describe other important features.

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Section 2018.EXHIBIT C Disclosure Statements

Things You Should Know Before You Buy
Long-Term Care Partnership Insurance

Long-Term Care Partnership Insurance	• A long-term care partnership insurance policy may pay most of the costs for your care in a nursing home. Many policies also pay for care at home or other community settings. Since policies can vary in coverage, you should read his policy and make sure you understand what it covers before you buy it.
	• You should not buy this long-term care partnership insurance policy unless you can afford to pay the premiums every year. Remember that the company can increase premiums in the future. For single premium policies, delete this language; for noncancellable policies, delete the second sentence only.
	• The personal worksheet includes questions designed to help you and the company determine whether this policy is suitable for your needs.
Medicare	• Medicare does not pay for most long-term care.
Medicaid	• Medicaid will generally pay for long-term care if you have very little income and few assets. You probably should not buy this policy if you are now eligible for Medicaid.
	• Many people become eligible for Medicaid after they have used up their own financial resources by paying for long-term care services.
	• When Medicaid pays your spouse's nursing home bills, you are allowed to keep your house and furniture, a living allowance, and some of your joint assets.
	• Your choice of long-term care services may be limited if you are receiving Medicaid. To learn more about Medicaid, contact your local or state Medicaid agency.

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Shopper's Guide	•	Make sure the insurance company or agent gives you a copy of a book called the National Association of Insurance Commissioners' "Shopper's Guide to Long-Term Care Insurance." Read it carefully. If you have decided to apply for long-term care insurance, you have the right to return the policy within 30 days and get back any premium you have paid if you are dissatisfied for any reason or choose not to purchase the policy.
Counseling	•	Free counseling and additional information about long-term care insurance are available through your State insurance counseling program. Contact the Illinois Department of Insurance or Department on Aging for more information about the senior health insurance counseling program in Illinois.

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Section 2018.EXHIBIT D Long-Term Care Partnership Insurance Suitability Letter

Dear [Applicant]:

Your recent application for long-term care insurance included a "personal worksheet," which asked questions about your finances and your reasons for buying long-term care insurance. For your protection, Illinois law requires us to consider this information when we review your application, to avoid selling a policy to those who may not need coverage.

[Your answers indicate that long-term care insurance may not meet your financial needs. We suggest that you review the information provided along with your application, including the booklet "Shopper's Guide to Long-Term Care Insurance" and the page titled "Things You Should Know Before Buying Long-Term Care Insurance." The Illinois Department of Insurance also has information about long-term care insurance and may be able to refer you to a counselor free of charge who can help you decide whether to buy this policy.]

[You chose not to provide any financial information for us to review.]

Drafting Note: Choose the paragraph that applies.

We have suspended our final review of your application. If, after careful consideration, you still believe this policy is what you want, check the appropriate box below and return this letter to us within the next 60 days. We will then continue reviewing your application and issue a policy if you meet our medical standards.

If we do not hear from you within the next 60 days, we will close your file and not issue you a policy. You should understand that you will not have any coverage until we hear back from you, approve your application and issue you a policy.

Please check one box and return in the enclosed envelope.

☐ Yes, [although my worksheet indicates that long-term care insurance may not be a suitable purchase,] I wish to purchase this coverage. Please resume review of my application. Delete the phrase in brackets if the applicant did not answer the questions about income.

☐ No. I have decided not to buy a policy at this time.

_____ _____

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APPLICANT'S SIGNATURE DATE

Please return to [issuer] at [address] by [date].

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NOTICE OF PROPOSED RULES

1) Heading of the Part: Military Sales Practices

2) Code Citation: 50 Ill. Adm. 2605

3)

Section Numbers:	Proposed Action:
2605.10	New Section
2605.20	New Section
2605.30	New Section
2605.40	New Section
2605.50	New Section
2605.60	New Section
2605.70	New Section

4) Statutory Authority: Implementing Section 5/429 and 5/500-70 [215 ILCS 5/429 and 500-70] and authorized by Section 5/401 and 5/500-145 of the Illinois Insurance Code [215 ILCS 5/401 and 500-145]

5) A Complete Description of the Subjects and Issues Involved: The purpose of this new Part will be to set forth standards to protect active duty service members of the United States Armed Forces from dishonest and predatory insurance sales practices by declaring certain identified practices to be false, misleading, deceptive or unfair. Illinois' promulgation of this regulation will be based on the recently adopted NAIC Model # 568.

6) Any published studies or reports, along with the sources of underlying data, that were used when comprising this rulemaking: None

7) Will this rulemaking replace any emergency rulemaking currently in effect? No

8) Does this rulemaking contain an automatic repeal date? No

9) Does this rulemaking contain incorporations by reference? Yes

10) Are there any other proposed rulemakings pending on this Part? No

11) Statement of Statewide Policy Objectives: This rulemaking will not require a local government to establish, expand or modify its activities in such a way as to necessitate additional expenditures from local revenues.

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12) Time, Place, and Manner in which interested persons may comment on this proposed rulemaking: Persons who wish to comment on this proposed rulemaking may submit written comments no later than 45 days after the publication of this Notice to:

Robert E. Wagner, Deputy General Counsel Department of Financial and Professional Regulation Division of Insurance 320 West Washington, 4th Floor Springfield, Illinois 62767-0001 217/785-8714	or	Craig Cellini, Rules Coordinator Department of Financial and Professional Regulation 320 West Washington 3rd Floor Springfield, Illinois 62767-0001 217/785-0813

13) Initial Regulatory Flexibility Analysis:

A) Types of small businesses, small municipalities and not for profit corporations affected: Insurance producers

B) Reporting, bookkeeping or other procedures required for compliance: Please review the provisions of this Part.

C) Types of professional skills necessary for compliance: Insurance

14) Regulatory Agenda on which this rulemaking was summarized: July 2007

The full text of the Proposed Rules begins on the next page:

DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

NOTICE OF PROPOSED RULES

TITLE 50: INSURANCE
CHAPTER I: DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION
SUBCHAPTER ff: UNFAIR METHODS OF COMPETITION

PART 2605
MILITARY SALES PRACTICES

Section
2605.10 Purpose
2605.20 Scope
2605.30 Exemptions
2605.40 Definitions
2605.50 Practices Declared False, Misleading, Deceptive or Unfair on a Military Installation
2605.60 Practices Declared False, Misleading, Deceptive or Unfair Regardless of Location
2605.70 Noncompliance

AUTHORITY: Implementing Sections 429 and 500-70 [215 ILCS 5/429 and 500-70] and authorized by Sections 401 and 500-145 of the Illinois Insurance Code [215 ILCS 5/401 and 500-145].

SOURCE: Adopted at 31 Ill. Reg. _____, effective _____.

Section 2605.10 Purpose

a) The purpose of this Part is to set forth standards to protect active duty service members of the United States Armed Forces from dishonest and predatory insurance sales practices by declaring certain identified practices to be false, misleading, deceptive or unfair.

b) Nothing in this Part shall be construed to create or imply a private cause of action for a violation of this Part.

Section 2605.20 Scope

This Part shall apply only to the solicitation or sale of any life insurance or annuity product by an insurer or insurance producer to an active duty service member of the United States Armed Forces.

Section 2605.30 Exemptions

a) This Part shall not apply to solicitations or sales involving:

1) Credit insurance;

2) Group life insurance or group annuities when there is no in-person, face-to-face solicitation of individuals by an insurance producer or when the contract or certificate does not include a side fund;

3) An application to the existing insurer that issued the existing policy or contract when a contractual change or a conversion privilege is being exercised; or when the existing policy or contract is being replaced by the same insurer pursuant to a program filed with and approved by the Director; or when a term conversion privilege is exercised among corporate affiliates;

4) Individual stand-alone health policies, including disability income policies;

5) Contracts offered by Servicemembers' Group Life Insurance (SGLI) or Veterans' Group Life Insurance (VGLI), as authorized by 38 USC 1965 et seq.;

6) Life insurance contracts offered through or by a non-profit military association qualifying under section 501(c)(23) of the Internal Revenue Code (IRC) (26 USC 501(c)(23)), and that are not underwritten by an insurer; or

7) Contracts used to fund:

A) An employee pension or welfare benefit plan that is covered by the Employee Retirement and Income Security Act (ERISA);

B) A plan described by sections 401(a), 401(k), 403(b), 408(k) or 408(p) of the IRC, as amended, if established or maintained by an employer;

C) A government or church plan defined in section 414 of the IRC, a government or church welfare benefit plan, or a deferred compensation plan of a state or local government or tax exempt organization under section 457 of the IRC;

D) A nonqualified deferred compensation arrangement established or maintained by an employer or plan sponsor;

E) Settlements of or assumptions of liabilities associated with personal injury litigation or any dispute or claim resolution process; or

F) Prearranged funeral contracts.

b) Nothing in this Section shall be construed to abrogate the ability of nonprofit organizations (and/or other organizations) to educate members of the United States Armed Forces in accordance with Department of Defense DoD Instruction 1344.07 - Personal Commercial Solicitation on DoD Installations or successor directive.

c) For purposes of this Part, general advertisements, direct mail and internet marketing shall not constitute "solicitation". Telephone marketing shall not constitute "solicitation" provided the caller explicitly and conspicuously discloses that the product concerned is life insurance and makes no statements that avoid a clear and unequivocal statement that life insurance is the subject matter of the solicitation. Provided, however, nothing in this subsection shall be construed to exempt an insurer or insurance producer from this Part in any in-person, face-to-face meeting established as a result of the "solicitation" exemptions identified in this subsection.

Section 2605.40 Definitions

For purposes of this Part:

Active Duty means full-time duty in the active military service of the United States and includes members of the reserve component (National Guard and Reserve) while serving under published orders for active duty or full-time training. The term does not include members of the reserve component who are

performing active duty or active duty for training under military calls or orders specifying periods of less than 31 calendar days.

Code means the Illinois Insurance Code [215 ILCS 5].

Department means the Department of Financial and Professional Regulation.

Department of Defense (DoD) Personnel means all active duty service members and all civilian employees, including nonappropriated fund employees and special government employees, of the Department of Defense.

Door to Door means a solicitation or sales method whereby an insurance producer proceeds randomly or selectively from household to household without prior specific appointment.

Director means the Director of the Illinois Department of Financial and Professional Regulation-Division of Insurance.

Division means the Illinois Department of Financial and Professional Regulation-Division of Insurance.

General Advertisement means an advertisement having as its sole purpose the promotion of the reader's or viewer's interest in the concept of insurance, or the promotion of the insurer or the insurance producer.

Insurer means an insurance company required to be licensed under the laws of this State to provide life insurance products, including annuities.

Insurance Producer means a person required to be licensed under the laws of this State to sell, solicit, or negotiate insurance. [215 ILCS 5/500-10]

Known or Knowingly means, depending on its use in this Part, the insurance producer or insurer had actual awareness, or, in the exercise of ordinary care, should have known, at the time of the act or practice complained of, that the person solicited is a service member or is a service member with a pay grade of E-4 or below.

Life Insurance means insurance coverage on human lives, including benefits of endowment and annuities, and may include benefits in the event of death or

dismemberment by accident and benefits for disability income and, unless otherwise specifically excluded, includes individually issued annuities.

Military Installation means any federally owned, leased, or operated base, reservation, post, camp, building, or other facility to which service members are assigned for duty, including barracks, transient housing, and family quarters.

MyPay is a Defense Finance and Accounting Service (DFAS) web-based system that enables service members to process certain discretionary pay transactions or provide updates to personal information data elements without using paper forms.

Service Member means any active duty officer (commissioned and warrant) or enlisted member of the United States Armed Forces.

Side Fund means a fund or reserve that is part of or otherwise attached to a life insurance policy (excluding individually issued annuities) by rider, endorsement or other mechanism that accumulates premium or deposits with interest or by other means. The term does not include:

accumulated value or cash value or secondary guarantees provided by a universal life policy;

cash values provided by a whole life policy that are subject to standard nonforfeiture law for life insurance; or

a premium deposit fund that:

contains only premiums paid in advance that accumulate at interest;

imposes no penalty for withdrawal;

does not permit funding beyond future required premiums;

is not marketed or intended as an investment; and

does not carry a commission, either paid or calculated.

Specific Appointment means a prearranged appointment agreed upon by both parties and definite as to place and time.

United States Armed Forces means all components of the Army, Navy, Air Force, Marine Corps, and Coast Guard.

Section 2605.50 Practices Declared False, Misleading, Deceptive or Unfair on a Military Installation

a) The following acts or practices, when committed on a military installation by an insurer or insurance producer with respect to the in-person, face-to-face solicitation of life insurance, are declared to be false, misleading, deceptive or unfair:

1) Knowingly soliciting the purchase of any life insurance product "door to door" or without first establishing a specific appointment for each meeting with the prospective purchaser.

2) Soliciting service members in a group or "mass" audience or in a "captive" audience where attendance is not voluntary.

3) Knowingly making appointments with or soliciting service members during their normally scheduled duty hours.

4) Making appointments with or soliciting service members in barracks, day rooms, unit areas, or transient personnel housing or other areas where the installation commander has prohibited solicitation.

5) Soliciting the sale of life insurance without first obtaining permission from the installation commander or the commander's designee.

6) Posting unauthorized bulletins, notices or advertisements.

7) Failing to present DD Form 2885, Personal Commercial Solicitation Evaluation, to service members solicited, or encouraging service members solicited not to complete or submit a DD Form 2885.

8) Knowingly accepting an application for life insurance or issuing a policy of life insurance on the life of an enlisted member of the United States

Armed Forces without first obtaining for the insurer's files a completed copy of any required form that confirms that the applicant has received counseling or fulfilled any other similar requirement for the sale of life insurance established by regulations, directives or rules of the DoD or any branch of the Armed Forces.

b) The following acts or practices, when committed on a military installation by an insurer or insurance producer, constitute corrupt practices, improper influences or inducements and are declared to be false, misleading, deceptive or unfair:

1) Using DoD personnel, directly or indirectly, as a representative or agent in any official or business capacity, with or without compensation, with respect to the solicitation or sale of life insurance to service members.

2) Using an insurance producer to participate in any United States Armed Forces sponsored education or orientation program.

Section 2605.60 Practices Declared False, Misleading, Deceptive or Unfair Regardless of Location

a) The following acts or practices by an insurer or insurance producer constitute corrupt practices or improper influences or inducements and are declared to be false, misleading, deceptive or unfair:

1) Submitting, processing or assisting in the submission or processing of any allotment form or similar device used by the United States Armed Forces to direct a service member's pay to a third party for the purchase of life insurance. The foregoing includes, but is not limited to, using or assisting in using a service member's MyPay account or other similar internet or electronic medium for such purposes. This subsection (a)(1) does not prohibit assisting a service member by providing insurer or premium information necessary to complete any allotment form.

2) Knowingly receiving funds from a service member for the payment of premium from a depository institution with which the service member has no formal banking relationship. For purposes of this Section, a formal banking relationship is established when the depository institution:

A) provides the service member a deposit agreement and periodic statements and makes the disclosures required by the Truth in Savings Act (12 USC 4301 et seq.) and the regulations promulgated under that Act; and

B) permits the service member to make deposits and withdrawals unrelated to the payment or processing of insurance premiums.

3) Employing any device or method or entering into any agreement whereby funds received from a service member by allotment for the payment of insurance premiums are identified on the service member's Leave and Earnings Statement or equivalent or successor form as "Savings" or "Checking" and where the service member has no formal banking relationship as defined in subsection (a)(2).

4) Entering into any agreement with a depository institution for the purpose of receiving funds from a service member whereby the depository institution, with or without compensation, agrees to accept direct deposits from a service member with whom it has no formal banking relationship.

5) Using DoD personnel, directly or indirectly, as a representative or agent in any official or unofficial capacity, with or without compensation, with respect to the solicitation or sale of life insurance to service members who are junior in rank or grade, or to the family members of such personnel.

6) Offering or giving anything of value, directly or indirectly, to DoD personnel to procure their assistance in encouraging, assisting or facilitating the solicitation or sale of life insurance to another service member.

7) Knowingly offering or giving anything of value to a service member with a pay grade of E-4 or below for his or her attendance at any event where an application for life insurance is solicited.

8) Advising a service member with a pay grade of E-4 or below to change his or her income tax withholding or State of legal residence for the sole purpose of increasing disposable income to purchase life insurance.

b) The following acts or practices by an insurer or insurance producer lead to confusion regarding source, sponsorship, approval or affiliation and are declared to be false, misleading, deceptive or unfair:

1) Making any representation, or using any device, title, descriptive name or identifier that has the tendency or capacity to confuse or mislead a service member into believing that the insurer, insurance producer or product offered is affiliated, connected or associated with, endorsed, sponsored, sanctioned or recommended by the U.S. Government, the United States Armed Forces, or any state or federal agency or government entity. Examples of prohibited insurance producer titles include, but are not limited to, "Battalion Insurance Counselor", "Unit Insurance Advisor", "Servicemen's Group Life Insurance Conversion Consultant" or "Veteran's Benefits Counselor". Nothing in this subsection (b)(1) shall be construed to prohibit a person from using a professional designation awarded after the successful completion of a course of instruction in the business of insurance by an accredited institution of higher learning. Such designations include, but are not limited to, Chartered Life Underwriter (CLU), Chartered Financial Consultant (ChFC), Certified Financial Planner (CFP), Master of Science in Financial Services (MSFS), or Masters of Science in Financial Planning (MS).

2) Soliciting the purchase of any life insurance product through the use of or in conjunction with any third party organization that promotes the welfare of or assists members of the United States Armed Forces in a manner that has the tendency or capacity to confuse or mislead a service member into believing that either the insurer, insurance producer or insurance product is affiliated, connected or associated with, endorsed, sponsored, sanctioned or recommended by the U.S. Government or the United States Armed Forces.

c) The following acts or practices by an insurer or insurance producer lead to confusion regarding premiums, costs or investment returns and are declared to be false, misleading, deceptive or unfair:

1) Using or describing the credited interest rate on a life insurance policy in a manner that implies that the credited interest rate is a net return on premium paid.

2) Excluding individually issued annuities, misrepresenting the mortality costs of a life insurance product, including stating or implying that the product "costs nothing" or is "free".

d) The following acts or practices by an insurer or insurance producer regarding SGLI or VGLI are declared to be false, misleading, deceptive or unfair:

1) Making any representation regarding the availability, suitability, amount, cost, exclusions or limitations to coverage provided to a service member or dependents by SGLI or VGLI, which is false, misleading or deceptive.

2) Making any representation regarding conversion requirements, including the costs of coverage, or exclusions or limitations to coverage of SGLI or VGLI to private insurers that is false, misleading or deceptive.

3) Suggesting, recommending or encouraging a service member to cancel or terminate his or her SGLI policy or issuing a life insurance policy that replaces an existing SGLI policy unless the replacement shall take effect upon or after the service member's separation from the United States Armed Forces.

e) The following acts or practices by an insurer and or insurance producer regarding disclosure are declared to be false, misleading, deceptive or unfair:

1) Deploying, using or contracting for any lead generating materials designed exclusively for use with service members that do not clearly and conspicuously disclose that the recipient will be contacted by an insurance producer, if that is the case, for the purpose of soliciting the purchase of life insurance.

2) Failing to disclose that a solicitation for the sale of life insurance will be made when establishing a specific appointment for an in-person, face-to-face meeting with a prospective purchaser.

3) Excluding individually issued annuities, failing to clearly and conspicuously disclose the fact that the product being sold is life insurance.

4) Failing to make, at the time of sale or offer to an individual known to be a service member, the written disclosures required by Section 10 of the Military Personnel Financial Services Protection Act (Pub. L. No. 109-290, p.16).

5) Excluding individually issued annuities, when the sale is conducted in-person face-to-face with an individual known to be a service member, failing to provide the applicant at the time the application is taken:

A) an explanation of any free look period with instructions on how to cancel if a policy is issued; and

B) either a copy of the application or a written disclosure. The copy of the application or the written disclosure shall clearly and concisely set out the type of life insurance, the death benefit applied for and its expected first year cost. A basic illustration that meets the requirements of 50 Ill. Adm. Code 1406 shall be deemed sufficient to meet this requirement for a written disclosure.

f) The following acts or practices by an insurer or insurance producer with respect to the sale of certain life insurance products are declared to be false, misleading, deceptive or unfair:

1) Excluding individually issued annuities, recommending the purchase of any life insurance product that includes a side fund to a service member in pay grades E-4 and below unless the insurer has reasonable grounds for believing that the life insurance death benefit, standing alone, is suitable.

2) Offering for sale or selling a life insurance product that includes a side fund to a service member in pay grades E-4 and below who is currently enrolled in SGLI, unless, after the completion of a needs assessment, the insurer demonstrates that the applicant's SGLI death benefit, together with any other military survivor benefits, savings and investments, survivor income, and other life insurance are insufficient to meet the applicant's insurable needs for life insurance.

A) "Insurable needs" are the risks associated with premature death taking into consideration the financial obligations and immediate

and future cash needs of the applicant's estate and/or survivors or dependents.

B) "Other military survivor benefits" include, but are not limited to: the Death Gratuity, Funeral Reimbursement, Transition Assistance, Survivor and Dependents' Educational Assistance, Dependency and Indemnity Compensation, TRICARE Healthcare benefits, Survivor Housing Benefits and Allowances, Federal Income Tax Forgiveness, and Social Security Survivor Benefits.

3) Excluding individually issued annuities, offering for sale or selling any life insurance contract that includes a side fund:

A) unless interest credited accrues from the date of deposit to the date of withdrawal and permits withdrawals without limit or penalty;

B) unless the applicant has been provided with a schedule of effective rates of return based upon cash flows of the combined product. For this disclosure, the effective rate of return will consider all premiums and cash contributions made by the policyholder and all cash accumulations and cash surrender values available to the policyholder in addition to life insurance coverage. This schedule will be provided for at least each policy year from 1 to 10 and for every fifth policy year thereafter ending at age 100, policy maturity or final expiration; and

C) that by default diverts or transfers funds accumulated in the side fund to pay, reduce or offset any premiums due.

4) Excluding individually issued annuities, offering for sale or selling any life insurance contract that, after considering all policy benefits, including but not limited to endowment, return of premium or persistency, does not comply with standard nonforfeiture law for life insurance.

5) Selling any life insurance product to an individual known to be a service member that excludes coverage if the insured's death is related to war, declared or undeclared, or any act related to military service except for an accidental death coverage, e.g., double indemnity, which may be excluded.

Section 2605.70 Noncompliance

a) Failure of an insurer to comply with the requirements of this Part shall subject the insurer to the applicable provisions of Section 403A of the Code; or

b) Failure of an insurance producer to comply with requirements of this Part shall be an unfair trade practice, and evidence of incompetence or untrustworthiness in the conduct of business under Section 500-70(a)(7) and (8) of the Code.

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

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1) Heading of the Part: Medical Payment

2) Code Citation: 89 Ill. Adm. Code 140

3)

Section Numbers:	Proposed Action:
140.462	Amendment
140.463	Amendment

4) Statutory Authority: Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/12-13]

5) Complete Description of the Subjects and Issues Involved: This proposed amendment implements the change that allows services rendered by a licensed clinical professional counselor (LCPC) to be recognized as an eligible behavioral health encounter.

6) Published studies or reports, and sources of underlying data, used to compose this rulemaking: None

7) Will this rulemaking replace any emergency rulemaking currently in effect? No

8) Does this rulemaking contain an automatic repeal date? No

9) Does this rulemaking contain incorporations by reference? No

10) Are there any other proposed rulemakings pending on this Part? Yes

Section Numbers:	Proposed Action:	Illinois Register Citation:
140.930	Amendment	31 Ill. Reg. 9731; July 13, 2007
140.491	Amendment	31 Ill. Reg. 10566; July 27, 2007

11) Statement of Statewide Policy Objective: This rulemaking does not affect units of local government.

12) Time, Place, and Manner in Which Interested Persons May Comment on this Proposed Rulemaking: Any interested parties may submit comments, data, views, or arguments concerning this proposed rulemaking. All comments must be in writing and should be addressed to:

Tamara Tanzillo Hoffman
Chief of Staff

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

Illinois Department of Healthcare and Family Services
201 South Grand Avenue E., 3rd Floor
Springfield IL 62763-0002

217/557-7157

The Department requests the submission of written comments within 30 days after the publication of this Notice. The Department will consider all written comments it receives during the first notice period as required by Section 5-40 of the Illinois Administrative Procedure Act [5 ILCS 100/5-40].

These proposed amendments may have an impact on small businesses, small municipalities, and not-for-profit corporations as defined in Sections 1-75, 1-80 and 1-85 of the Illinois Administrative Procedure Act [5 ILCS 100/1-75, 1-80, 1-85]. These entities may submit comments in writing to the Department at the above address in accordance with the regulatory flexibility provisions in Section 5-30 of the Illinois Administrative Procedure Act [5 ILCS 100/5-30]. These entities shall indicate their status as small businesses, small municipalities, or not-for-profit corporations as part of any written comments they submit to the Department.

13) Initial Regulatory Flexibility Analysis:

A) Types of small businesses, small municipalities and not-for-profit corporations affected: Licensed Clinical Professional Counselors

B) Reporting, bookkeeping or other procedures required for compliance: None

C) Types of professional skills necessary for compliance: None

14) Regulatory Agenda on which this rulemaking was summarized: July 2007

The full text of the Proposed Amendments begins on the next page:

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

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TITLE 89: SOCIAL SERVICES
CHAPTER I: DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
SUBCHAPTER d: MEDICAL PROGRAMS

PART 140
MEDICAL PAYMENT

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Section
140.1 Incorporation By Reference
140.2 Medical Assistance Programs
140.3 Covered Services Under Medical Assistance Programs
140.4 Covered Medical Services Under AFDC-MANG for non-pregnant persons who are 18 years of age or older (Repealed)
140.5 Covered Medical Services Under General Assistance
140.6 Medical Services Not Covered
140.7 Medical Assistance Provided to Individuals Under the Age of Eighteen Who Do Not Qualify for AFDC and Children Under Age Eight
140.8 Medical Assistance For Qualified Severely Impaired Individuals
140.9 Medical Assistance for a Pregnant Woman Who Would Not Be Categorically Eligible for AFDC/AFDC-MANG if the Child Were Already Born Or Who Do Not Qualify As Mandatory Categorically Needy
140.10 Medical Assistance Provided to Incarcerated Persons

SUBPART B: MEDICAL PROVIDER PARTICIPATION

Section
140.11 Enrollment Conditions for Medical Providers
140.12 Participation Requirements for Medical Providers
140.13 Definitions
140.14 Denial of Application to Participate in the Medical Assistance Program
140.15 Recovery of Money
140.16 Termination or Suspension of a Vendor's Eligibility to Participate in the Medical Assistance Program
140.17 Suspension of a Vendor's Eligibility to Participate in the Medical Assistance Program
140.18 Effect of Termination or Revocation on Persons Associated with Vendor
140.19 Application to Participate or for Reinstatement Subsequent to Termination,

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Suspension or Barring
140.20 Submittal of Claims
140.21 Reimbursement for QMB Eligible Medical Assistance Recipients and QMB Eligible Only Recipients and Individuals Who Are Entitled to Medicare Part A or Part B and Are Eligible for Some Form of Medicaid Benefits
140.22 Magnetic Tape Billings (Repealed)
140.23 Payment of Claims
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140.25 Overpayment or Underpayment of Claims
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140.33 Publication of List of Sanctioned Entities
140.35 False Reporting and Other Fraudulent Activities
140.40 Prior Approval for Medical Services or Items
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140.43 Post Approval for Items or Services When Prior Approval Cannot Be Obtained
140.55 Recipient Eligibility Verification (REV) System
140.71 Reimbursement for Medical Services Through the Use of a C-13 Invoice Voucher Advance Payment and Expedited Payments
140.72 Drug Manual (Recodified)
140.73 Drug Manual Updates (Recodified)

SUBPART C: PROVIDER ASSESSMENTS

Section
140.80 Hospital Provider Fund
140.82 Developmentally Disabled Care Provider Fund
140.84 Long Term Care Provider Fund
140.94 Medicaid Developmentally Disabled Provider Participation Fee Trust Fund/Medicaid Long Term Care Provider Participation Fee Trust Fund
140.95 Hospital Services Trust Fund
140.96 General Requirements (Recodified)
140.97 Special Requirements (Recodified)
140.98 Covered Hospital Services (Recodified)

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140.99	Hospital Services Not Covered (Recodified)
140.100	Limitation On Hospital Services (Recodified)
140.101	Transplants (Recodified)
140.102	Heart Transplants (Recodified)
140.103	Liver Transplants (Recodified)
140.104	Bone Marrow Transplants (Recodified)
140.110	Disproportionate Share Hospital Adjustments (Recodified)
140.116	Payment for Inpatient Services for GA (Recodified)
140.117	Hospital Outpatient and Clinic Services (Recodified)
140.200	Payment for Hospital Services During Fiscal Year 1982 (Recodified)
140.201	Payment for Hospital Services After June 30, 1982 (Repealed)
140.202	Payment for Hospital Services During Fiscal Year 1983 (Recodified)
140.203	Limits on Length of Stay by Diagnosis (Recodified)
140.300	Payment for Pre-operative Days and Services Which Can Be Performed in an Outpatient Setting (Recodified)
140.350	Copayments (Recodified)
140.360	Payment Methodology (Recodified)
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140.362	Pre July 1, 1989 Services (Recodified)
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140.364	Prepayment Review (Recodified)
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140.369	Groupings (Recodified)
140.370	Rate Calculation (Recodified)
140.371	Payment (Recodified)
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140.373	Utilization (Repealed)
140.374	Alternatives (Recodified)
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140.398 Hearings (Recodified)

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AUTHORITY: Implementing and authorized by Articles III, IV, V, VI and Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/Arts. III, IV, V, VI and 12-13].

SOURCE: Adopted at 3 Ill. Reg. 24, p. 166, effective June 10, 1979; rule repealed and new rule adopted at 6 Ill. Reg. 8374, effective July 6, 1982; emergency amendment at 6 Ill. Reg. 8508, effective July 6, 1982, for a maximum of 150 days; amended at 7 Ill. Reg. 681, effective December 30, 1982; amended at 7 Ill. Reg. 7956, effective July 1, 1983; amended at 7 Ill. Reg. 8308, effective July 1, 1983; amended at 7 Ill. Reg. 8271, effective July 5, 1983; emergency amendment at 7 Ill. Reg. 8354, effective July 5, 1983, for a maximum of 150 days; amended at 7 Ill. Reg. 8540, effective July 15, 1983; amended at 7 Ill. Reg. 9382, effective July 22, 1983;

amended at 7 Ill. Reg. 12868, effective September 20, 1983; peremptory amendment at 7 Ill. Reg. 15047, effective October 31, 1983; amended at 7 Ill. Reg. 17358, effective December 21, 1983; amended at 8 Ill. Reg. 254, effective December 21, 1983; emergency amendment at 8 Ill. Reg. 580, effective January 1, 1984, for a maximum of 150 days; codified at 8 Ill. Reg. 2483; amended at 8 Ill. Reg. 3012, effective February 22, 1984; amended at 8 Ill. Reg. 5262, effective April 9, 1984; amended at 8 Ill. Reg. 6785, effective April 27, 1984; amended at 8 Ill. Reg. 6983, effective May 9, 1984; amended at 8 Ill. Reg. 7258, effective May 16, 1984; emergency amendment at 8 Ill. Reg. 7910, effective May 22, 1984, for a maximum of 150 days; amended at 8 Ill. Reg. 7910, effective June 1, 1984; amended at 8 Ill. Reg. 10032, effective June 18, 1984; emergency amendment at 8 Ill. Reg. 10062, effective June 20, 1984, for a maximum of 150 days; amended at 8 Ill. Reg. 13343, effective July 17, 1984; amended at 8 Ill. Reg. 13779, effective July 24, 1984; Sections 140.72 and 140.73 recodified to 89 Ill. Adm. Code 141 at 8 Ill. Reg. 16354; amended (by adding sections being codified with no substantive change) at 8 Ill. Reg. 17899; peremptory amendment at 8 Ill. Reg. 18151, effective September 18, 1984; amended at 8 Ill. Reg. 21629, effective October 19, 1984; peremptory amendment at 8 Ill. Reg. 21677, effective October 24, 1984; amended at 8 Ill. Reg. 22097, effective October 24, 1984; peremptory amendment at 8 Ill. Reg. 22155, effective October 29, 1984; amended at 8 Ill. Reg. 23218, effective November 20, 1984; emergency amendment at 8 Ill. Reg. 23721, effective November 21, 1984, for a maximum of 150 days; amended at 8 Ill. Reg. 25067, effective December 19, 1984; emergency amendment at 9 Ill. Reg. 407, effective January 1, 1985, for a maximum of 150 days; amended at 9 Ill. Reg. 2697, effective February 22, 1985; amended at 9 Ill. Reg. 6235, effective April 19, 1985; amended at 9 Ill. Reg. 8677, effective May 28, 1985; amended at 9 Ill. Reg. 9564, effective June 5, 1985; amended at 9 Ill. Reg. 10025, effective June 26, 1985; emergency amendment at 9 Ill. Reg. 11403, effective June 27, 1985, for a maximum of 150 days; amended at 9 Ill. Reg. 11357, effective June 28, 1985; amended at 9 Ill. Reg. 12000, effective July 24, 1985; amended at 9 Ill. Reg. 12306, effective August 5, 1985; amended at 9 Ill. Reg. 13998, effective September 3, 1985; amended at 9 Ill. Reg. 14684, effective September 13, 1985; amended at 9 Ill. Reg. 15503, effective October 4, 1985; amended at 9 Ill. Reg. 16312, effective October 11, 1985; amended at 9 Ill. Reg. 19138, effective December 2, 1985; amended at 9 Ill. Reg. 19737, effective December 9, 1985; amended at 10 Ill. Reg. 238, effective December 27, 1985; emergency amendment at 10 Ill. Reg. 798, effective January 1, 1986, for a maximum of 150 days; amended at 10 Ill. Reg. 672, effective January 6, 1986; amended at 10 Ill. Reg. 1206, effective January 13, 1986; amended at 10 Ill. Reg. 3041, effective January 24, 1986; amended at 10 Ill. Reg. 6981, effective April 16, 1986; amended at 10 Ill. Reg. 7825, effective April 30, 1986; amended at 10 Ill. Reg. 8128, effective May 7, 1986; emergency amendment at 10 Ill. Reg. 8912, effective May 13, 1986, for a maximum of 150 days; amended at 10 Ill. Reg. 11440, effective June 20, 1986; amended at 10 Ill. Reg. 14714, effective August 27, 1986; amended at 10 Ill. Reg. 15211, effective September 12, 1986; emergency amendment at 10 Ill. Reg. 16729, effective September 18, 1986, for a maximum of 150 days; amended at 10 Ill. Reg.

18808, effective October 24, 1986; amended at 10 Ill. Reg. 19742, effective November 12, 1986; amended at 10 Ill. Reg. 21784, effective December 15, 1986; amended at 11 Ill. Reg. 698, effective December 19, 1986; amended at 11 Ill. Reg. 1418, effective December 31, 1986; amended at 11 Ill. Reg. 2323, effective January 16, 1987; amended at 11 Ill. Reg. 4002, effective February 25, 1987; Section 140.71 recodified to 89 Ill. Adm. Code 141 at 11 Ill. Reg. 4302; amended at 11 Ill. Reg. 4303, effective March 6, 1987; amended at 11 Ill. Reg.7664, effective April 15, 1987; emergency amendment at 11 Ill. Reg. 9342, effective April 20, 1987, for a maximum of 150 days; amended at 11 Ill. Reg. 9169, effective April 28, 1987; amended at 11 Ill. Reg. 10903, effective June 1, 1987; amended at 11 Ill. Reg. 11528, effective June 22, 1987; amended at 11 Ill. Reg. 12011, effective June 30, 1987; amended at 11 Ill. Reg. 12290, effective July 6, 1987; amended at 11 Ill. Reg. 14048, effective August 14, 1987; amended at 11 Ill. Reg. 14771, effective August 25, 1987; amended at 11 Ill. Reg. 16758, effective September 28, 1987; amended at 11 Ill. Reg. 17295, effective September 30, 1987; amended at 11 Ill. Reg. 18696, effective October 27, 1987; amended at 11 Ill. Reg. 20909, effective December 14, 1987; amended at 12 Ill. Reg. 916, effective January 1, 1988; emergency amendment at 12 Ill. Reg. 1960, effective January 1, 1988, for a maximum of 150 days; amended at 12 Ill. Reg. 5427, effective March 15, 1988; amended at 12 Ill. Reg. 6246, effective March 16, 1988; amended at 12 Ill. Reg. 6728, effective March 22, 1988; Sections 140.900 thru 140.912 and 140.Table H and 140.Table I recodified to 89 Ill. Adm. Code 147.5 thru 147.205 and 147.Table A and 147.Table B at 12 Ill. Reg. 6956; amended at 12 Ill. Reg. 6927, effective April 5, 1988; Sections 140.940 thru 140.972 recodified to 89 Ill. Adm. Code 149.5 thru 149.325 at 12 Ill. Reg. 7401; amended at 12 Ill. Reg. 7695, effective April 21, 1988; amended at 12 Ill. Reg. 10497, effective June 3, 1988; amended at 12 Ill. Reg. 10717, effective June 14, 1988; emergency amendment at 12 Ill. Reg. 11868, effective July 1, 1988, for a maximum of 150 days; amended at 12 Ill. Reg. 12509, effective July 15, 1988; amended at 12 Ill. Reg. 14271, effective August 29, 1988; emergency amendment at 12 Ill. Reg. 16921, effective September 28, 1988, for a maximum of 150 days; amended at 12 Ill. Reg. 16738, effective October 5, 1988; amended at 12 Ill. Reg. 17879, effective October 24, 1988; amended at 12 Ill. Reg. 18198, effective November 4, 1988; amended at 12 Ill. Reg. 19396, effective November 6, 1988; amended at 12 Ill. Reg. 19734, effective November 15, 1988; amended at 13 Ill. Reg. 125, effective January 1, 1989; amended at 13 Ill. Reg. 2475, effective February 14, 1989; amended at 13 Ill. Reg. 3069, effective February 28, 1989; amended at 13 Ill. Reg. 3351, effective March 6, 1989; amended at 13 Ill. Reg. 3917, effective March 17, 1989; amended at 13 Ill. Reg. 5115, effective April 3, 1989; amended at 13 Ill. Reg. 5718, effective April 10, 1989; amended at 13 Ill. Reg. 7025, effective April 24, 1989; Sections 140.850 thru 140.896 recodified to 89 Ill. Adm. Code 146.5 thru 146.225 at 13 Ill. Reg. 7040; amended at 13 Ill. Reg. 7786, effective May 20, 1989; Sections 140.94 thru 140.398 recodified to 89 Ill. Adm. Code 148.10 thru 148.390 at 13 Ill. Reg. 9572; emergency amendment at 13 Ill. Reg. 10977, effective July 1, 1989, for a maximum of 150 days; emergency expired November 28, 1989; amended at 13 Ill. Reg. 11516, effective July 3, 1989;

amended at 13 Ill. Reg. 12119, effective July 7, 1989; Section 140.110 recodified to 89 Ill. Adm. Code 148.120 at 13 Ill. Reg. 12118; amended at 13 Ill. Reg. 12562, effective July 17, 1989; amended at 13 Ill. Reg. 14391, effective August 31, 1989; emergency amendment at 13 Ill. Reg. 15473, effective September 12, 1989, for a maximum of 150 days; amended at 13 Ill. Reg. 16992, effective October 16, 1989; amended at 14 Ill. Reg. 190, effective December 21, 1989; amended at 14 Ill. Reg. 2564, effective February 9, 1990; emergency amendment at 14 Ill. Reg. 3241, effective February 14, 1990, for a maximum of 150 days; emergency expired July 14, 1990; amended at 14 Ill. Reg. 4543, effective March 12, 1990; emergency amendment at 14 Ill. Reg. 4577, effective March 6, 1990, for a maximum of 150 days; emergency expired August 3, 1990; emergency amendment at 14 Ill. Reg. 5575, effective April 1, 1990, for a maximum of 150 days; emergency expired August 29, 1990; emergency amendment at 14 Ill. Reg. 5865, effective April 3, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 7141, effective April 27, 1990; emergency amendment at 14 Ill. Reg. 7249, effective April 27, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 10062, effective June 12, 1990; amended at 14 Ill. Reg. 10409, effective June 19, 1990; emergency amendment at 14 Ill. Reg. 12082, effective July 5, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 13262, effective August 6, 1990; emergency amendment at 14 Ill. Reg. 14184, effective August 16, 1990, for a maximum of 150 days; emergency amendment at 14 Ill. Reg. 14570, effective August 22, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 14826, effective August 31, 1990; amended at 14 Ill. Reg. 15366, effective September 12, 1990; amended at 14 Ill. Reg. 15981, effective September 21, 1990; amended at 14 Ill. Reg. 17279, effective October 12, 1990; amended at 14 Ill. Reg. 18057, effective October 22, 1990; amended at 14 Ill. Reg. 18508, effective October 30, 1990; amended at 14 Ill. Reg. 18813, effective November 6, 1990; Notice of Corrections to Adopted Amendment at 15 Ill. Reg. 1174; amended at 14 Ill. Reg. 20478, effective December 7, 1990; amended at 14 Ill. Reg. 20729, effective December 12, 1990; amended at 15 Ill. Reg. 298, effective December 28, 1990; emergency amendment at 15 Ill. Reg. 592, effective January 1, 1991, for a maximum of 150 days; amended at 15 Ill. Reg. 1051, effective January 18, 1991; amended at 15 Ill. Reg. 6220, effective April 18, 1991; amended at 15 Ill. Reg. 6534, effective April 30, 1991; amended at 15 Ill. Reg. 8264, effective May 23, 1991; amended at 15 Ill. Reg. 8972, effective June 17, 1991; amended at 15 Ill. Reg. 10114, effective June 21, 1991; amended at 15 Ill. Reg. 10468, effective July 1, 1991; amended at 15 Ill. Reg. 11176, effective August 1, 1991; emergency amendment at 15 Ill. Reg. 11515, effective July 25, 1991, for a maximum of 150 days; emergency expired December 22, 1991; emergency amendment at 15 Ill. Reg. 12919, effective August 15, 1991, for a maximum of 150 days; emergency expired January 12, 1992; emergency amendment at 15 Ill. Reg. 16366, effective October 22, 1991, for a maximum of 150 days; amended at 15 Ill. Reg. 17318, effective November 18, 1991; amended at 15 Ill. Reg. 17733, effective November 22, 1991; emergency amendment at 16 Ill. Reg. 300, effective December 20, 1991, for a maximum of 150 days; amended at 16 Ill. Reg. 174, effective December 24, 1991; amended at 16 Ill. Reg. 1877, effective January 24, 1992; amended at 16 Ill.

Reg. 3552, effective February 28, 1992; amended at 16 Ill. Reg. 4006, effective March 6, 1992; amended at 16 Ill. Reg. 6408, effective March 20, 1992; expedited correction at 16 Ill. Reg. 11348, effective March 20, 1992; amended at 16 Ill. Reg. 6849, effective April 7, 1992; amended at 16 Ill. Reg. 7017, effective April 17, 1992; amended at 16 Ill. Reg. 10050, effective June 5, 1992; amended at 16 Ill. Reg. 11174, effective June 26, 1992; emergency amendment at 16 Ill. Reg. 11947, effective July 10, 1992, for a maximum of 150 days; amended at 16 Ill. Reg. 12186, effective July 24, 1992; emergency amendment at 16 Ill. Reg. 13337, effective August 14, 1992, for a maximum of 150 days; emergency amendment at 16 Ill. Reg. 15109, effective September 21, 1992, for a maximum of 150 days; amended at 16 Ill. Reg. 15561, effective September 30, 1992; amended at 16 Ill. Reg. 17302, effective November 2, 1992; emergency amendment at 16 Ill. Reg. 18097, effective November 17, 1992, for a maximum of 150 days; amended at 16 Ill. Reg. 19146, effective December 1, 1992; expedited correction at 17 Ill. Reg. 7078, effective December 1, 1992; amended at 16 Ill. Reg. 19879, effective December 7, 1992; amended at 17 Ill. Reg. 837, effective January 11, 1993; amended at 17 Ill. Reg. 1112, effective January 15, 1993; amended at 17 Ill. Reg. 2290, effective February 15, 1993; amended at 17 Ill. Reg. 2951, effective February 17, 1993; amended at 17 Ill. Reg. 3421, effective February 19, 1993; amended at 17 Ill. Reg. 6196, effective April 5, 1993; amended at 17 Ill. Reg. 6839, effective April 21, 1993; amended at 17 Ill. Reg. 7004, effective May 17, 1993; emergency amendment at 17 Ill. Reg. 11201, effective July 1, 1993, for a maximum of 150 days; emergency amendment at 17 Ill. Reg. 15162, effective September 2, 1993, for a maximum of 150 days; emergency amendment suspended at 17 Ill. Reg. 18902, effective October 12, 1993; emergency amendment at 17 Ill. Reg. 18152, effective October 1, 1993, for a maximum of 150 days; amended at 17 Ill. Reg. 18571, effective October 8, 1993; emergency amendment at 17 Ill. Reg. 18611, effective October 1, 1993, for a maximum of 150 days; amended at 17 Ill. Reg. 20999, effective November 24, 1993; emergency amendment repealed at 17 Ill. Reg. 22583, effective December 20, 1993; amended at 18 Ill. Reg. 3620, effective February 28, 1994; amended at 18 Ill. Reg. 4250, effective March 4, 1994; amended at 18 Ill. Reg. 5951, effective April 1, 1994; emergency amendment at 18 Ill. Reg. 10922, effective July 1, 1994, for a maximum of 150 days; emergency amendment suspended at 18 Ill. Reg. 17286, effective November 15, 1994; emergency amendment repealed at 19 Ill. Reg. 5839, effective April 4, 1995; amended at 18 Ill. Reg. 11244, effective July 1, 1994; amended at 18 Ill. Reg. 14126, effective August 29, 1994; amended at 18 Ill. Reg. 16675, effective November 1, 1994; amended at 18 Ill. Reg. 18059, effective December 19, 1994; amended at 19 Ill. Reg. 1082, effective January 20, 1995; amended at 19 Ill. Reg. 2933, effective March 1, 1995; emergency amendment at 19 Ill. Reg. 3529, effective March 1, 1995, for a maximum of 150 days; amended at 19 Ill. Reg. 5663, effective April 1, 1995; amended at 19 Ill. Reg. 7919, effective June 5, 1995; emergency amendment at 19 Ill. Reg. 8455, effective June 9, 1995, for a maximum of 150 days; emergency amendment at 19 Ill. Reg. 9297, effective July 1, 1995, for a maximum of 150 days; emergency amendment at 19 Ill. Reg. 10252, effective July 1, 1995, for a maximum of 150 days; amended at 19 Ill. Reg. 13019, effective

September 5, 1995; amended at 19 Ill. Reg. 14440, effective September 29, 1995; emergency amendment at 19 Ill. Reg. 14833, effective October 6, 1995, for a maximum of 150 days; amended at 19 Ill. Reg. 15441, effective October 26, 1995; amended at 19 Ill. Reg. 15692, effective November 6, 1995; amended at 19 Ill. Reg. 16677, effective November 28, 1995; amended at 20 Ill. Reg. 1210, effective December 29, 1995; amended at 20 Ill. Reg. 4345, effective March 4, 1996; amended at 20 Ill. Reg. 5858, effective April 5, 1996; amended at 20 Ill. Reg. 6929, effective May 6, 1996; amended at 20 Ill. Reg. 7922, effective May 31, 1996; amended at 20 Ill. Reg. 9081, effective June 28, 1996; emergency amendment at 20 Ill. Reg. 9312, effective July 1, 1996, for a maximum of 150 days; amended at 20 Ill. Reg. 11332, effective August 1, 1996; amended at 20 Ill. Reg. 14845, effective October 31, 1996; emergency amendment at 21 Ill. Reg. 705, effective December 31, 1996, for a maximum of 150 days; emergency amendment at 21 Ill. Reg. 3734, effective March 5, 1997, for a maximum of 150 days; amended at 21 Ill. Reg. 4777, effective April 2, 1997; amended at 21 Ill. Reg. 6899, effective May 23, 1997; amended at 21 Ill. Reg. 9763, effective July 15, 1997; amended at 21 Ill. Reg. 11569, effective August 1, 1997; emergency amendment at 21 Ill. Reg. 13857, effective October 1, 1997, for a maximum of 150 days; amended at 22 Ill. Reg. 1416, effective December 29, 1997; amended at 22 Ill. Reg. 4412, effective February 27, 1998; amended at 22 Ill. Reg. 7024, effective April 1, 1998; amended at 22 Ill. Reg. 10606, effective June 1, 1998; emergency amendment at 22 Ill. Reg. 13117, effective July 1, 1998, for a maximum of 150 days; amended at 22 Ill. Reg. 16302, effective August 28, 1998; amended at 22 Ill. Reg. 18979, effective September 30, 1998; amended at 22 Ill. Reg. 19898, effective October 30, 1998; emergency amendment at 22 Ill. Reg. 22108, effective December 1, 1998, for a maximum of 150 days; emergency expired April 29, 1999; amended at 23 Ill. Reg. 5796, effective April 30, 1999; amended at 23 Ill. Reg. 7122, effective June 1, 1999; emergency amendment at 23 Ill. Reg. 8236, effective July 1, 1999, for a maximum of 150 days; amended at 23 Ill. Reg. 9874, effective August 3, 1999; amended at 23 Ill. Reg. 12697, effective October 1, 1999; amended at 23 Ill. Reg. 13646, effective November 1, 1999; amended at 23 Ill. Reg. 14567, effective December 1, 1999; amended at 24 Ill. Reg. 661, effective January 3, 2000; amended at 24 Ill. Reg. 10277, effective July 1, 2000; emergency amendment at 24 Ill. Reg. 10436, effective July 1, 2000, for a maximum of 150 days; amended at 24 Ill. Reg. 15086, effective October 1, 2000; amended at 24 Ill. Reg. 18320, effective December 1, 2000; emergency amendment at 24 Ill. Reg. 19344, effective December 15, 2000, for a maximum of 150 days; amended at 25 Ill. Reg. 3897, effective March 1, 2001; amended at 25 Ill. Reg. 6665, effective May 11, 2001; amended at 25 Ill. Reg. 8793, effective July 1, 2001; emergency amendment at 25 Ill. Reg. 8850, effective July 1, 2001, for a maximum of 150 days; amended at 25 Ill. Reg. 11880, effective September 1, 2001; amended at 25 Ill. Reg. 12820, effective October 8, 2001; amended at 25 Ill. Reg. 14957, effective November 1, 2001; emergency amendment at 25 Ill. Reg. 16127, effective November 28, 2001, for a maximum of 150 days; emergency amendment at 25 Ill. Reg. 16292, effective December 3, 2001, for a maximum of 150 days; emergency amendment at 26 Ill. Reg. 514,

effective January 1, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 663, effective January 7, 2002; amended at 26 Ill. Reg. 4781, effective March 15, 2002; emergency amendment at 26 Ill. Reg. 5984, effective April 15, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 7285, effective April 29, 2002; emergency amendment at 26 Ill. Reg. 8594, effective June 1, 2002, for a maximum of 150 days; emergency amendment at 26 Ill. Reg. 11259, effective July 1, 2002, for a maximum of 150 days; emergency amendment at 26 Ill. Reg. 12461, effective July 29, 2002, for a maximum of 150 days; emergency amendment repealed at 26 Ill. Reg. 16593, effective October 22, 2002; emergency amendment at 26 Ill. Reg. 12772, effective August 12, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 13641, effective September 3, 2002; amended at 26 Ill. Reg. 14789, effective September 26, 2002; emergency amendment at 26 Ill. Reg. 15076, effective October 1, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 16303, effective October 25, 2002; amended at 26 Ill. Reg. 17751, effective November 27, 2002; amended at 27 Ill. Reg. 768, effective January 3, 2003; amended at 27 Ill. Reg. 3041, effective February 10, 2003; amended at 27 Ill. Reg. 4364, effective February 24, 2003; amended at 27 Ill. Reg. 7823, effective May 1, 2003; amended at 27 Ill. Reg. 9157, effective June 2, 2003; emergency amendment at 27 Ill. Reg. 10813, effective July 1, 2003, for a maximum of 150 days; amended at 27 Ill. Reg. 13784, effective August 1, 2003; amended at 27 Ill. Reg. 14799, effective September 5, 2003; emergency amendment at 27 Ill. Reg. 15584, effective September 20, 2003, for a maximum of 150 days; emergency amendment at 27 Ill. Reg. 16161, effective October 1, 2003, for a maximum of 150 days; amended at 27 Ill. Reg. 18629, effective November 26, 2003; amended at 28 Ill. Reg. 2744, effective February 1, 2004; amended at 28 Ill. Reg. 4958, effective March 3, 2004; emergency amendment at 28 Ill. Reg. 6622, effective April 19, 2004, for a maximum of 150 days; amended at 28 Ill. Reg. 7081, effective May 3, 2004; emergency amendment at 28 Ill. Reg. 8108, effective June 1, 2004, for a maximum of 150 days; amended at 28 Ill. Reg. 9640, effective July 1, 2004; emergency amendment at 28 Ill. Reg. 10135, effective July 1, 2004, for a maximum of 150 days; amended at 28 Ill. Reg. 11161, effective August 1, 2004; emergency amendment at 28 Ill. Reg. 12198, effective August 11, 2004, for a maximum of 150 days; amended at 28 Ill. Reg. 13775, effective October 1, 2004; amended at 28 Ill. Reg. 14804, effective October 27, 2004; amended at 28 Ill. Reg. 15513, effective November 24, 2004; amended at 29 Ill. Reg. 831, effective January 1, 2005; amended at 29 Ill. Reg. 6945, effective May 1, 2005; emergency amendment at 29 Ill. Reg. 8509, effective June 1, 2005, for a maximum of 150 days; emergency amendment at 29 Ill. Reg. 12534, effective August 1, 2005, for a maximum of 150 days; amended at 29 Ill. Reg. 14957, effective September 30, 2005; emergency amendment at 29 Ill. Reg. 15064, effective October 1, 2005, for a maximum of 150 days; emergency amendment repealed by emergency rulemaking at 29 Ill. Reg. 15985, effective October 5, 2005, for the remainder of the maximum 150 days; emergency amendment at 29 Ill. Reg. 15610, effective October 1, 2005, for a maximum of 150 days; emergency amendment at 29 Ill. Reg. 16515, effective October 5, 2005, for a maximum of 150 days; amended at 30 Ill. Reg. 349, effective December 28, 2005; emergency amendment at 30 Ill.

Reg. 573, effective January 1, 2006, for a maximum of 150 days; amended at 30 Ill. Reg. 796, effective January 1, 2006; amended at 30 Ill. Reg. 2802, effective February 24, 2006; amended at 30 Ill. Reg. 10370, effective May 26, 2006; emergency amendment at 30 Ill. Reg. 12376, effective July 1, 2006, for a maximum of 150 days; emergency amendment at 30 Ill. Reg. 13909, effective August 2, 2006, for a maximum of 150 days; amended at 30 Ill. Reg. 14280, effective August 18, 2006; expedited correction at 31 Ill. Reg. 1745, effective August 18, 2006; emergency amendment at 30 Ill. Reg. 17970, effective November 1, 2006, for a maximum of 150 days; amended at 30 Ill. Reg. 18648, effective November 27, 2006; emergency amendment at 30 Ill. Reg. 19400, effective December 1, 2006, for a maximum of 150 days; amended at 31 Ill. Reg. 388, effective December 29, 2006; emergency amendment at 31 Ill. Reg. 1580, effective January 1, 2007, for a maximum of 150 days; amended at 31 Ill. Reg. 2413, effective January 19, 2007; amended at 31 Ill. Reg. 5561, effective March 30, 2007; amended at 31 Ill. Reg. 6930, effective April 29, 2007; amended at 31 Ill. Reg. 8485, effective May 30, 2007; emergency amendment at 31 Ill. Reg. 10115, effective June 30, 2007, for a maximum of 150 days; amended at 31 Ill. Reg. _____, effective _____.

SUBPART D: PAYMENT FOR NON-INSTITUTIONAL SERVICES

Section 140.462 Covered Services in Clinics

Payment shall be made to clinics for the following types of services when provided by, or under the direction of, a physician:

a) Hospital-Based Organized Clinics

1) With respect to those hospital-based organized clinics that qualify as Maternal and Child Health clinics, as described in Section 140.461(f)(1), covered services are those described in subsection (e)~~ below~~, as appropriate.

2) With respect to all other hospital-based organized clinics, covered services are those described in 89 Ill. Adm. Code 148.

b) Encounter Rate Clinics

1) With respect to those encounter rate clinics that qualify as Maternal and Child Health providers, as described in Section 140.924(a)(2)(B), covered services are those described in Section 140.922.

2) With respect to all other encounter rate clinics, covered services are medical services which provide for the continuous health care needs of persons who elect to use this type of service.

c) Rural Health Clinics

Those core services for which the clinic or center may bill an encounter as described in 42 CFR 440.90 (2000) are as follows:

1) Physician's Services, including covered services of nurse practitioners, nurse midwives and physician-supervised physician assistants.

2) Other services for which a separate encounter may be billed include dentist and behavioral health services as defined in Section 140.463(a).~~as clinical psychologist or clinical social worker services.~~

3) Medically-necessary services and supplies furnished by or under the direction of a physician or dentist within the scope of licensed practice that have been included in the cost report but neither fee-for-service nor encounter billings may be billed. Some examples of these services include:

A) medical case management;

B) laboratory services;

C) occupational therapy;

D) patient transportation;

E) pharmacy services;

F) physical therapy;

G) podiatric services;

H) speech and hearing services;

I) x-ray services;

J) health education;

K) nutrition services;

L) optometric services.

4) A rural health clinic (RHC) that adds behavioral health services or dental services on or after October 1, 2001, must notify the Department in writing. These services are to be billed as an encounter with a procedure code that appropriately identifies the service provided.

5) Any service that is no longer provided on or after October 1, 2001, or any new service added on or after October 1, 2001, must be communicated to the Department in writing prior to billing for the services.

6) Effective January 1, 2001, the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) precludes fee-for-service billings for any RHC services.

d) Federally Qualified Health Centers
Those core services for which the clinic or center may bill an encounter as described in 42 CFR 440.90 (2000) are as follows:

1) Physician's services, including covered services of nurse midwives, nurse practitioners and physician-supervised physician assistants.

2) Other services for which separate encounters may be billed include dentists and behavioral health services as defined in Section 140.463(a).~~as clinical psychologists or clinical social worker services.~~

3) Medically-necessary services and supplies furnished by or under the direction of a physician or dentist within the scope of licensed practice have been included in the cost report but neither fee-for-service nor encounter billings may be billed. Some examples of these services include:

A) medical case management;

B) laboratory services;

C) occupational therapy;

D) patient transportation;

E) pharmacy services;

F) physical therapy;

G) podiatric services;

H) optometric services;

I) speech and hearing services;

J) x-ray services;

K) health education;

L) nutrition services.

4) A federally qualified health center (FQHC) that adds behavioral health services or dental services on or after October 1, 2001, must notify the Department in writing. These services are to be billed as an encounter with a procedure code that appropriately identifies the service.

5) Any service that is no longer provided on or after October 1, 2001, or any new service added on or after October 1, 2001, must be communicated to the Department in writing.

6) Effective January 1, 2001, the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) precludes fee-for-service billings for any FQHC services provided.

e) Maternal and Child Health Clinics
Payment shall be made to the Maternal and Child Health clinics identified in Section 140.461(f)(1) for the following services when provided by, or under the direction of, a physician:

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

1) In the case of clinics described in Section~~Sections~~ 140.461(f)(1)(A) and ~~140.461~~(f)(1)(B), primary care services delivered by the clinic, which must include, but are not necessarily limited to:

A) Early, periodic, screening, diagnostic, and treatment (EPSDT) services as defined in Section 140.485;

B) Childhood risk assessments to determine potential need for mental health and substance abuse assessment and/or treatment;

C) Regular immunizations for the prevention of childhood diseases;

D) Follow-up ambulatory medical care deemed necessary, recommended, or prescribed by a physician as a result of an EPSDT screening;

E) Routine prenatal care, including risk assessment, for pregnant women; and

F) Specialty care as medically needed.

2) In the case of clinics described in Section 140.461(f)(1)(C), primary care and specialty services delivered by the clinic, which must include, but are not necessarily limited to:

A) Prenatal care, including risk assessment (one risk assessment per pregnancy);

B) All ambulatory treatment services deemed medically necessary, recommended, or prescribed by a physician as the result of the assessment; and

C) Services to pregnant women with diagnosed substance abuse or addiction problems.

3) In the case of clinics described in Section 140.461(f)(1)(D):

A) Comprehensive medical and referral services.

B) Primary care services, which must include, but are not necessarily limited to:

i) early, periodic, screening, diagnostic, and treatment (EPSDT) services as defined in Section 140.485;

ii) regular immunizations for the prevention of childhood diseases; and

iii) follow-up ambulatory medical care deemed necessary, recommended, or prescribed by a physician as the result of an EPSDT screening.

C) Pediatric specialty services, which must include, at a minimum, necessary treatment for:

i) asthma,

ii) congenital heart disease,

iii) diabetes, and

iv) sickle cell anemia.

D) Ambulatory treatment for other medical conditions as specified in the center's certificate application and as approved by the Department.

f) School Based/Linked Health Clinics (Centers)
Covered services are the following services, when delivered in a school based/linked health center setting as described in Section 140.461(g)~~)~~:

1) Basic medical services: well child or adolescent exams, consisting of a comprehensive health history, complete physical assessment, screening procedures and age appropriate anticipatory guidance; immunizations; EPSDT services; diagnosis and treatment of acute illness and injury; basic laboratory tests; prescriptions and dispensing of commonly used medications for identified health conditions, in accordance with Medical

Practice and Pharmacy Practice Acts; and acute management and on-going monitoring of chronic conditions, such as asthma, diabetes and seizure disorders.

2) Reproductive health services: gynecological exams; diagnosis and treatment of sexually transmitted diseases; family planning; prescribing and dispensing of birth control or referral for birth control services; pregnancy testing; treatment or referral for prenatal and postpartum care; and cancer screening.

(Source: Amended at 31 Ill. Reg. _____, effective _____)

Section 140.463 Clinic Service Payment

a) Definitions

"Behavioral Health Services", for the purposes of this Section, means services provided by a licensed clinical psychologist, ~~or~~ licensed clinical social worker or licensed clinical professional counselor.

"Center", for the purposes of this Section, means both a federally qualified health center and a rural health clinic.

"Federally Qualified Health Center" or "~~(~~FQHC"~~)~~ means a health care provider that receives a grant under Section 330 of the Public Health Service Act (Public Law 78-410) (42 USC 1395x(aa)(3)) or has been determined to meet the requirements for receiving such a grant by the Health Resources and Services Administration, U.S. Department of Health and Human Services.

"Rural Health Clinic" or "~~(~~RHC"~~)~~ means a health care provider that has been designated by the Public Health Service, U.S. Department of Health and Human Services, or by the Governor, and approved by the Public Health Service, in accordance with the Rural Health Clinics Act (Public Law 95-210) (42 USC 1395x(aa)(2)) to be an RHC.

b) Reimbursement

The Center will be reimbursed under a prospective payment system for 100 percent of the average of the costs that are reasonable and related to the cost of furnishing such services by the Center in accordance with the provisions of

federal law (42 USC 1396a(aa)). Baseline payment rates will be determined individually for each enrolled Center. Once determined, the baseline payment rate will be adjusted annually using the Medicare Economic Index (MEI). Payment for services provided on or after January 1, 2001, shall be made using specific rates for each Center as specified in this Section.

1) Baseline Payment Rates

A) For each Center, the Department will calculate a baseline medical encounter rate and, for each Center that is enrolled with the Department to provide Behavioral Health Services or dental services, the Department will calculate a baseline Behavioral Health Services or dental encounter rate, using the methodology specified in this subsection (b).

i) The cost basis for the baseline rates shall be drawn from individual Center cost reports for Center fiscal years ending in 1999 and 2000 or, in the instance of a Center that did not operate during the entirety of those periods, cost reports that cover the portions of those periods during which the Center was in operation.

ii) Pending federal approval, for dates of service provided by an FQHC on or after January 1, 2006, the cost basis for the baseline rates shall be the greater of an encounter rate using the criteria under subsection (b)(1)(A)(i) of this Section, or the same criteria that uses the Center's cost reports ending in 2002 and 2003 in place of cost reports ending in 1999 and 2000.

B) The baseline payment rates shall be based upon allowable costs, reported by the Center, that are determined by the Department to be reasonable and efficient. The method for determining allowable cost factors is similar to that used for Medicare (42 USC 1395g), with the following significant differences. The Department's methodology shall:

i) Consider costs associated with services not covered under Medicare (e.g., pharmacy, patient transportation, medical

case management, health education, nutritional counseling).

ii) Apply reasonable constraints on allowable cost, as described in subsection (b)(10) of this Section.

iii) Apply reasonable constraints on the total cost per encounter.

C) The baseline payment rates for a Center shall be the average (arithmetic mean) of the annual reasonable costs per encounter, calculated separately for each of the fiscal years for which cost report data must be submitted using the methodology specified in subsections (b)(2), (3) and (4) of this Section for the medical encounter rate, dental encounter rate, and Behavioral Health Services encounter rate, respectively.

2) Annual Reasonable Cost Per Medical Encounter

A) The annual reasonable cost per medical encounter shall be the lesser of:

i) The annual cost per encounter, as calculated in subsection (b)(2)(D) of this Section; or

ii) The reasonable cost of providing a medical encounter, which shall be 105 percent of the Statewide median of the calculated annual costs per encounter for FQHCs or RHCs, as the case may be.

B) The core services component.
The core services component is the sum of the following two components:

i) The allowable direct cost per encounter, which is the quotient of the allowable direct cost, as defined in subsection (b)(1)(B) of this Section, for core services divided by the greater of the number of encounters reported by direct staff (e.g., staff specified in subsection (b)(10)(A) and, for the determination of encounter payment rates

effective prior to January 1, 2002, subsection (b)(10)(C)); or the number of encounters resulting from the application of the minimum efficiency standards found in subsections (b)(10)(A) and (b)(10)(C); and

ii) The allowable overhead cost per encounter, which is the product of the allowable direct cost per encounter multiplied by the Center's allowable overhead rate factor.

C) Supplemental services component.
The supplemental services component is the sum of the following two components:

i) The allowable supplemental cost per encounter, which is the quotient of the cost of services (e.g., pharmacy, patient transportation, medical case management, health education, nutritional counseling), excepting core services, dental services and, effective January 1, 2002, Behavioral Health Services, provided by the Center, divided by the greater of the number of encounters reported by direct staff; or the number of encounters resulting from application of the minimum productivity standards found in subsections (b)(10)(A) and (b)(10)(C) of this Section; and

ii) The allowable overhead cost per encounter, which is the product of the allowable supplemental cost per encounter multiplied by the Center's allowable overhead rate factor.

D) Annual cost per encounter.
The annual cost per medical encounter is the sum of the core services component, as determined in subsection (b)(2)(B) of this Section, and the supplemental services component, as determined in subsection (b)(2)(C).

3) Annual Reasonable Cost Per Dental Encounter

A) The annual reasonable cost per dental encounter shall be the lesser of:

i) The annual cost per encounter, as calculated in subsection (b)(3)(B) of this Section; or

ii) The reasonable cost of providing a dental encounter, which shall be 105 percent of the Statewide median of the calculated annual costs per encounter for FQHCs or RHCs, as the case may be.

B) Annual cost per encounter.
The annual cost per encounter is the sum of the following two components:

i) The allowable direct cost per encounter, which is the quotient of the allowable direct dental cost, as defined in subsection (b)(1)(B), divided by the greater of the number of encounters reported by direct dental staff; or the number of encounters resulting from the application of the minimum efficiency standard found in subsection (b)(10)(B); and

ii) The allowable overhead cost per encounter, which is the product of the allowable direct cost per encounter multiplied by the Center's allowable overhead rate factor.

4) Annual Reasonable Cost Per Behavioral Health Service Encounter
Effective for services provided on or after January 1, 2002, a separate annual reasonable cost per Behavioral Health Service encounter shall be determined.

A) The annual reasonable cost per Behavioral Health Service encounter shall be the lesser of the following:

i) The annual cost per encounter, as calculated in subsection (b)(4)(B) of this Section.

ii) The reasonable cost of providing a Behavioral Health Service encounter, which shall be 105 percent of the Statewide median of the calculated annual cost per encounter for FQHCs or RHCs, as the case may be.

B) Annual cost per encounter.
The annual cost per encounter is the sum of the following two components:

i) The allowable direct cost per encounter, which is the quotient of the allowable direct cost for Behavioral Health Services, as defined in subsection (b)(1)(B) of this Section, divided by the greater of the number of encounters reported by direct behavioral health staff; or the number of encounters resulting from the application of the minimum efficiency standard found in subsection (b)(10)(C); and

ii) The allowable overhead cost per encounter, which is the product of the allowable direct cost per encounter multiplied by the Center's allowable overhead rate factor.

5) For any individual eligible under the medical assistance programs, a Center may bill only one medical encounter, one dental encounter, and one behavioral health encounter per day. A Center will be reimbursed for a service only if it has enrolled with the Department to provide that service.

6) Claims submitted to the Department must identify all services provided during the encounter.

7) Cost Basis
Each Center must annually complete a cost report, in a format specified by the Department, for the Center's fiscal year. Each FQHC must also annually submit a copy of financial statements audited by an independent Certified Public Accountant. The cost report and audited financial statements must be filed with the Department within 180 days after the close of the Center's fiscal year, except for cost reports and audited financial statements for Center fiscal years 1999 and 2000 which, in the case of FQHCs, must be filed with the Department no later than November 30, 2001, and in the case of RHCs, must be filed no later than March 30, 2002. Except for the first year during which the Center begins operations, the cost report must cover a full fiscal year ending on June 30 or other fiscal year that has been approved by the Department. Payments

will be withheld from any Center that has not submitted the cost report by the applicable filing date, and no payments will be made until such time as the reports or audited statements are received and approved by the Department.

8) Establishment of Initial Year Payment Amount for a New Center
For any Center that begins operation on or after January 1, 2001, the payment rate per encounter shall be the median of the payment rates per encounter of neighboring FQHCs or RHCs with similar caseloads, as determined by the Department. If the Department determines that there are no such comparable Centers, then the rate per encounter shall be the median of the payment rates per encounter Statewide for all FQHCs or RHCs, as the case may be.

9) Rate Adjustments

A) Initial rate determinations.

i) On or about January 1, 2002, the Department shall determine the medical and dental encounter rates for each participating FQHC. These rates shall be paid for services provided on or after January 1, 2001. Claims submitted and adjudicated prior to the entry of these rates into the Department's claims processing system shall be reconciled for each affected FQHC.

ii) On or about January 1, 2003, the Department shall determine the medical and dental encounter rates for each participating RHC. These rates shall be paid for services provided on or after January 1, 2001. Claims submitted and adjudicated prior to the entry of these rates into the Department's claims processing system shall be reconciled for each affected RHC.

B) Annual adjustment.

i) Beginning January 1, 2002, and annually thereafter, except as specified in subsection (b)(9)(B)(ii) of this Section, the Department will adjust baseline rates by the most recently

available MEI. The adjusted rates shall be paid for services provided on or after the date of adjustment.

ii) In the instance of a Center that provided Behavioral Health Services prior to January 1, 2002, for the purpose of applying the January 1, 2002, adjustment by the most recently available MEI, the baseline medical services encounter rate applicable for services provided from January 1, 2001, through December 31, 2001, shall be redetermined after removal of costs and encounters attributable to Behavioral Health Services.

C) Scope of service adjustment.
If a Center significantly changes its scope of services, the Center may request that new baseline encounter rates be determined. Adjustments to encounter rates will be made only if the change in the scope of services results in the inclusion of Behavioral Health Services or dental services or a difference of at least five percent from the Center's current rate. The Department may initiate a rate adjustment, based on audited financial statements or cost reports, if the scope of services has been modified to include Behavioral Health Services or dental services or would otherwise result in a change of at least five percent from the Center's current rate.

10) Reasonable Cost Considerations
The following minimum efficiency standards will be applied to determine reasonable cost:

A) Medical direct care productivity.
The Center must average 4,200 encounters annually per full-time equivalent (FTE) for physicians and 2,100 encounters per FTE for mid-level health care staff (i.e., physician assistants, nurse practitioners, specialized nurse practitioners and nurse midwives).

B) Dental direct care productivity.
The Center must average 1.5 encounters per hour per FTE for dentists.

C) Behavioral health direct care productivity.

The Center must average 2,100 annual encounters per FTE for licensed clinical psychologists, ~~and~~ licensed clinical social workers and licensed clinical professional counselors.

D) Guideline for non-physician health care staff.
The maximum ratio of staff is four FTE non-physician health care staff for each FTE staff subject to the direct care productivity standards in subsections (b)(10)(A) and (B) of this Section.

E) Allowable overhead.
The maximum Medicaid allowable overhead cost is 35 percent of allowable total cost.

11) Adjustments for Medical Services Paid for by a Managed Care Organization (MCO)
The Department shall make payment adjustments to a Center if it provides care through a contractual arrangement with a Medicaid MCO and is reimbursed an amount, reported to the Department, that is less than the minimum payment required in 42 USC 1396a(aa). The amount of any such payment adjustment shall be at a fixed annual rate as determined by the Department. For each Center so eligible, a payment adjustment shall take into consideration the total payments made by the MCO to the Center (including all payments made on a service-by-service, encounter or capitation basis). In the event that Center cost data related to MCO services are unavailable to the Department, an estimate of such costs may be used that takes into consideration other relevant data. Adjustments will be made, at least quarterly, only for Medicaid eligible services. All such services must be defined in a contract between the Center and the MCO. Such contracts must be made available to the Department.

12) Audits
All cost reports will be audited by the Department. The Center will be advised of any adjustment resulting from these audits.

13) Alternate Payment Methodology for Government-Operated Centers

A) A Center operated by a State or local government agency may elect to be reimbursed under the alternate payment methodology described in this subsection (b)(13).

B) The State or local government agency shall enter into an interagency or intergovernmental agreement, as appropriate, with the Department that specifies the responsibilities of the two parties with respect to services provided by the Center and the funding of those services.

C) The Center operated by a State or local government agency shall be reimbursed by the Department on a per encounter basis according to the provisions of subsections (b)(1) through (11) of this Section.

D) The State or local government agency shall certify the expenditure of public funds in excess of reimbursement received from the Department, under subsection (b)(13)(C) of this Section, and any reimbursement from other payers (e.g., an insurance company, a managed care organization) for services provided to individuals eligible for medical assistance programs administered by the Department, provided the funds were not derived from a federal funding source or were not otherwise used as a State or local match for federal funds. The certification shall be in the form and format specified by the Department. The certification shall be filed within 30 days after the submission of the annual cost report. The certification shall compare expenditures within that cost reporting period to payments received or receivable for that same period.

E) The certified expenditures shall be used by the Department to claim federal financial participation. Federal funds resulting from the claiming of the certified expenditures shall be distributed, according to the provisions of the agreement referenced in subsection (b)(13)(B) of this Section, to the State or the government agency that operates the Center that provided the services.

14) Alternate Payment Methodology for Certain Qualifying Centers

A) No later than 30 days after the initial rate determination specified in subsection (b)(9)(A) of this Section, the Department shall determine the eligibility of each Center for this alternative payment

methodology. A Center will qualify for this alternative payment methodology if the Department's estimate of the total amount to be paid to the Center for services provided during the 12-month period ending December 31, 2001, under the reimbursement policy and rates in effect prior to the initial rate determination, is greater than the total amount that will be paid for those same services under the initial rates. The Department shall notify each qualifying Center, in writing, of the result of this determination.

B) A qualifying Center may, for services provided from January 1, 2002~~,~~ through December 31, 2002, elect to be reimbursed under the alternate payment methodology described in this subsection (b)(14). A qualifying Center must notify the Department, in writing, no later than 30 days after the date of the written notification from the Department, of its election to be reimbursed under this alternative payment methodology.

C) A Center electing this alternative payment system shall be reimbursed by the Department on a per encounter basis according to the provisions of subsections (b)(1) through (11) of this Section, except the medical encounter payment rate shall be increased by an amount equal to twice the quotient resulting from the Department's estimate of the difference between the total amount to be paid to the Center for services provided during the 12-month period ending December 31, 2001, under the initial rates as determined in subsection (b)(9)(A); and the total amount that would have been paid under the payment rates in effect prior to the initial rate determination, divided by the Department's estimate of total medical encounters during the 12-month period ending December 31, 2001.

15) Alternate Behavioral Health Payment Methodology for Certain Qualifying Centers

Centers that are certified by the Department of Human Services-Division of Mental Health, or the Department of Children and Family Services to provide Behavioral Health Services may elect an alternate payment methodology for their Behavioral Health Services. An election of this alternate payment methodology will allow the Centers to be reimbursed under the provisions of 59 Ill. Adm. Code 132 for Behavioral Health

Services provided. A qualifying Center must notify the Department in writing, no later than 30 days after the date of the written notification from the Department, of its election to be reimbursed under this alternate payment methodology.

16) All service sites operated by a Center shall be reimbursed using the Center's established encounter rates, except in the instance where the site submitted separate cost reports and separate baseline rates were determined for the site.

c) Rate Appeals Process

1) All appeals of audit adjustments or rate determinations must be submitted in writing to the Department. Appeals must be submitted within 60 calendar days after the notification of such adjustments or rate determinations. If upheld, the revised audit adjustment or rate determination shall be made effective as of the beginning of the rate period.

2) To be accepted for review, the written appeal shall include the following:

A) The current approved reimbursement rate, allowable costs, and the additional reimbursable costs sought through the appeal.

B) A clear, concise statement of the basis for the appeal.

C) A detailed statement of financial, statistical, and related information in support of the appeal, indicating the relationship between the additional reimbursable costs as submitted and the circumstances creating the need for increased reimbursement.

D) A statement by the Center's chief executive officer or financial officer that the application of the rate appeal and information contained in the Center's reports, schedules, budgets, books, and records submitted are true and accurate.

3) Rate appeals may be considered for the following reasons:

A) Mechanical or clerical errors committed by the provider in

reporting historical expenses used in the calculation of allowable costs.

B) Mechanical or clerical errors committed by the Department in auditing historical expenses as reported and/or in calculating reimbursement rates.

4) The Department shall rule on all appeals within 120 calendar days after receipt of the complete appeal, except that, if additional information is required from the facility, the period shall be extended until such time as the information is provided.

5) Appeals shall be submitted to the Department's Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763-0002.

(Source: Amended at 31 Ill. Reg. _____, effective _____)

DEPARTMENT OF HUMAN SERVICES

NOTICE OF PROPOSED AMENDMENT

1) Heading of the Part: Child Care

2) Code Citation: 89 Ill. Adm. 50

3)

Section Number:	Proposed Action:
50.230	Amendment

4) Statutory Authority: Implementing Articles I through IXA and authorized by Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/Arts. I through IXA and 12-13]

5) A Complete Description of the Subjects and Issues involved: This rulemaking affects Human Capital Development. Pursuant to a recommendation from the Program Accountability and Efficiencies Workgroup, this rulemaking reduces the work requirement for families who do not receive TANF and need child care services in order to attend post-secondary education or training programs. This rulemaking also adds a Grade Point Average requirement to reflect current Department policy.

6) Published studies or reports, and sources of underlying data, used to compose this rulemaking: None

7) Will this rulemaking replace any emergency rulemaking currently in effect? No

8) Does this rulemaking contain an automatic repeal date? No

9) Does this rulemaking contain incorporations by reference? No

10) Are there any other proposed rulemakings pending on this Part? Yes

Section Number:	Proposed Action:	Illinois Register Citation:
50.410	Amendment	31 Ill. Reg. 5393; April 6, 2007

11) Statement of Statewide Policy Objectives: This rulemaking does not create or expand a State mandate.

12) Time, Place, and Manner in which interested persons may comment on this proposed rulemaking: Interested persons may present their comments concerning these rules within 45 days after the date of this issue of the *Illinois Register*. All requests and comments should be submitted in writing to:

DEPARTMENT OF HUMAN SERVICES

NOTICE OF PROPOSED AMENDMENT

Tracie Drew, Chief
Bureau of Administrative Rules and Procedures
Department of Human Services
100 South Grand Avenue East
Harris Building, 3rd Floor
Springfield, Illinois 62762

217/785-9772

13) Initial Regulatory Flexibility Analysis:

A) Types of small businesses, small municipalities and not-for-profit corporations affected: None

B) Reporting, bookkeeping or other procedures required for compliance: None

C) Types of professional skills necessary for compliance: None

14) Regulatory agenda on which this rulemaking was summarized: July 2007

The full text of the Proposed Amendment begins on the next page.

DEPARTMENT OF HUMAN SERVICES

NOTICE OF PROPOSED AMENDMENT

TITLE 89: SOCIAL SERVICES
CHAPTER IV: DEPARTMENT OF HUMAN SERVICES
SUBCHAPTER a: GENERAL PROGRAM PROVISIONS

PART 50
CHILD CARE

SUBPART A: GENERAL PROVISIONS

Section
50.101 Incorporation by Reference
50.110 Participant Rights and Responsibilities
50.120 Notification of Available Services
50.130 Child Care Overpayments and Recoveries

SUBPART B: APPLICABILITY

Section
50.210 Child Care
50.220 Method of Providing Child Care
50.230 Child Care Eligibility
50.235 Income Eligibility Criteria
50.240 Qualified Provider
50.250 Additional Service to Secure or Maintain Child Care

SUBPART C: PAYMENT FEES

Section
50.310 Fees for Child Care Services
50.320 Maximum Monthly Income and Parent Fee by Family Size, Income Level and Number of Children Receiving Full-time Care

SUBPART D: CHILD CARE ABUSE AND NEGLECT

Section
50.410 Provider Eligibility
50.420 Payment for Child Care Services

SUBPART E: GREAT START PROGRAM

DEPARTMENT OF HUMAN SERVICES

NOTICE OF PROPOSED AMENDMENT

Section
50.510 Great START Program
50.520 Method of Providing the Wage Supplement
50.530 Eligibility
50.540 Employer Responsibility
50.550 Notification of Eligibility
50.560 Phase-in of Wage Supplement Scale
50.570 Wage Supplement Scale
50.580 Evaluation

AUTHORITY: Implementing Articles I through IXA and authorized by Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/Arts. I through IXA and 12-13].

SOURCE: Emergency rules adopted at 21 Ill. Reg. 9502, effective July 1, 1997, for a maximum of 150 days; adopted at 21 Ill. Reg. 14961, effective November 10, 1997; emergency amendment at 22 Ill. Reg. 12816, effective July 1, 1998, for a maximum of 150 days; amended at 22 Ill. Reg. 21037, effective November 27, 1998; emergency amendment at 23 Ill. Reg. 10875, effective August 20, 1999, for maximum of 150 days; amended at 24 Ill. Reg 1058, effective January 10, 2000; emergency amendment at 24 Ill. Reg. 6604, effective April 5, 2000, for a maximum of 150 days; amended at 24 Ill. Reg. 13987, effective September 1, 2000; amended at 24 Ill. Reg. 15423, effective October 10, 2000; emergency amendment at 25 Ill. Reg. 2735, effective February 5, 2001, for a maximum of 150 days; amended at 25 Ill. Reg. 8176, effective June 23, 2001; emergency amendment at 25 Ill. Reg. 8443, effective July 1, 2001, for a maximum of 150 days; amended at 25 Ill. Reg. 14854, effective October 31, 2001; emergency amendment at 25 Ill. Reg. 16116, effective December 1, 2001, for a maximum of 150 days; amended at 26 Ill. Reg. 7113, effective April 25, 2002; amended at 27 Ill. Reg. 12090, effective July 14, 2003; amended at 27 Ill. Reg. 18411, effective November 24, 2003; amended at 28 Ill. Reg. 6895, effective April 23, 2004; emergency amendment at 28 Ill. Reg. 10121, effective July 1, 2004, for a maximum of 150 days; emergency expired November 27, 2004; amended at 29 Ill. Reg. 2687, effective February 4, 2005; emergency amendment at 29 Ill. Reg. 13253, effective August 11, 2005, for a maximum of 150 days; emergency expired January 7, 2006; amended at 30 Ill. Reg. 11190, effective June 6, 2006; amended at 31 Ill. Reg. _____, effective _____.

SUBPART B: APPLICABILITY

Section 50.230 Child Care Eligibility

a) Child care services are restricted to children under age 13 and to children under

age 19 who are under court supervision or have physical or mental incapacities as documented by a statement from a local health provider or other health professional.

b) Parents and other relatives eligible to receive child care services include:

1) Recipients of Temporary Assistance for Needy Families (TANF) under Article IV of the Public Aid Code participating in work and training activities as specified in their personal plans for employment and self-sufficiency who have been approved for child care benefits by the Department and who meet the monthly income ceilings in subsection (b)(2) of this Section.

2) Working families, including teen parents while they attend school to obtain a high school degree or its equivalent, whose monthly incomes do not exceed the following amounts by family size:

Family Size	Gross Monthly Income
2	$2,051
3	$2,533
4	$3,016
5	$3,498
6	$3,981
7	$4,071
8	$4,162

The above income guidelines will be indexed annually so that the thresholds are no less than 50% of the most current State Median Income for each family size.

3) Families who do not receive TANF and need child care services in order to attend school or training (up to and including the acquisition of the first Associate's~~Associate~~ Degree and/or the first Bachelor's Degree) whose monthly income does not exceed the monthly income ceilings in subsection (b)(2) of this Section. ~~Qualifying families are eligible to receive child care services needed to attend literacy and other adult basic education, English as a Second Language, GED preparation, and~~

~~vocational training for up to 24 non-consecutive months with no work requirement, after which they must work a monthly average of at least 20 hours per week in paid employment. Child care provided to a teen parent to obtain a high school degree, or its equivalent, does not count against this 24-month limit. Qualifying families are eligible to receive child care services to attend a 2 or 4 year college degree program if they work a monthly average of at least 10 hours per week in paid employment or a monthly average of at least 20 hours per week in a combination of paid employment and unpaid, educationally-required work activities such as student teaching, an internship, a clinical, a practicum or an apprenticeship.~~ Child care services approved under this Part must be~~shall be available during time periods that are~~ reasonably related to the ~~following activities performed outside the home: paid work, self-employment and~~ education or training activity, including class hours and research, study, laboratory, library and transportation time. ~~Families with a work requirement shall receive the same grace periods between jobs as persons who receive services pursuant to subsection (b)(2) of this Section.~~ If a parent is claimed as a dependent by another person for federal income tax purposes, that parent is only eligible if his or her income, when added to the income of the other person, does not exceed the monthly income ceiling in subsection (b)(2) of this Section for that family size. All education programs under this Part must be administered by an educational institution accredited under requirements of State law, including, but not limited to, the Barber, Cosmetology, Esthetics, and Nail Technology Act of 1985 [225 ILCS 410], the Real Estate Act of 2000 [225 ILCS 454], the Public Community College Act [110 ILCS 805], the University of Illinois Act [110 ILCS 305], the Chicago State University Law [110 ILCS 660], the Eastern Illinois University Law [110 ILCS 665], the Governors State University Law [110 ILCS 670], the Illinois State University Law [110 ILCS 675], the Northeastern Illinois University Law [110 ILCS 680], the Northern Illinois University Law [110 ILCS 685], the Western Illinois University Law [110 ILCS 690], or the Department of Financial and Professional Regulation.

A) Below Post-Secondary Education Eligibility and Participation Requirements

This category of education includes literacy and other adult basic education, English as a Second Language, and GED preparation programs. There is no work requirement for the first 24 non-

consecutive months the client participates. From the 25th month on, the client must work at least 20 hours per week. Child care provided to a teen parent to obtain a high school diploma or its equivalent does not count against this 24-month limit. Individuals enrolled in below post-secondary education must maintain a "C" average if this measurement is used by the institution to determine satisfactory progress. The individual will be allowed one semester below a "C" average to bring the grades up to a "C" average. When grades are not used, progress will be determined by the written policy of the institution to establish a comparable grade level upon completion of the academic term. The determination of satisfactory progress must be reported upon completion of the academic term or twice a year if the program is continuous for 12 months.

B) Vocational Education Eligibility and Participation Requirements This category of education prepares the individual for a specific job, and includes all programs that prepare the client for a specific type of work. The program may be offered by a public community college, public or private university, or private business/technical school. The program usually results in the receipt of a Certificate of Achievement or Completion and/or prepares the client for a specific job or to obtain a license required by some occupations. There is no work requirement for the first 24 non-consecutive months the client participates. From the 25th month on, the client must work at least 20 hours per week. Individuals enrolled in vocational education must maintain a "C" average if this measurement is used by the institution to determine satisfactory progress. The individual will be allowed one semester below a "C" average to bring the grades up to a "C" average. When grades are not used, progress will be determined by the written policy of the institution to establish a comparable grade level upon completion of the academic term. The determination of satisfactory progress must be reported upon completion of the academic term or twice a year if the program is continuous for 12 months.

C) Post-Secondary Education

This category of education includes all undergraduate college level courses that result in an Associate's or Bachelor's Degree. Families eligible to receive child care services while they attend an education or training program under this Section must:

i) be enrolled in a program accredited under requirements of State law as stated in subsection (b)(3) of this Section.

ii) not already have an Associate's or Bachelor's Degree, if requesting child care to earn an Associate's Degree. Child care will not be approved for attainment of a second Associate's Degree.

iii) not already have a Bachelor's Degree, if requesting child care to earn a Bachelor's Degree. Child care will not be approved for attainment of a second Bachelor's Degree.

iv) not be in an advanced degree program (beyond a Bachelor's Degree). Child care will not be approved for education beyond the attainment of a Bachelor's Degree.

There is no work requirement for the first 48 non-consecutive months the client participates. From the 49th month on, the client must work at least 20 hours per week. Clients who do not work and who need child care to attend college must maintain a cumulative 2.5 grade point average (on a 4.0 scale) if this measurement is used by the institution to determine satisfactory progress. Clients who work 20 hours or more per week in paid employment while they attend college must maintain a cumulative 2.0 GPA (on a 4.0 scale). In the absence of a GPA, satisfactory progress will be determined by the written policy of the institution. The determination of satisfactory progress, including test/retest results or GPA, must be reported upon completion of the academic term or twice a year if the program is continuous for 12 months. If the client's cumulative GPA falls below 2.5 or 2.0 for those students who work or at any time the client does not maintain satisfactory progress, the client may continue to go to school for another semester. If the cumulative GPA is below 2.5 or 2.0 two

semesters in a row, the client will be ineligible for child care until his or her GPA is at or above 2.5 or 2.0.

D) For child care services received under education/training, a parent enrolled in web-based courses or correspondence learning from an accredited university or college is only eligible for child care assistance if both of the following are met:

i) The class is offered only at a regularly scheduled time (i.e., 11:00 a.m. every Monday and Wednesday) or the parent must leave the home to have access to a computer. Web-based classes that the parent may take at any time do not fit this criteria.

ii) The child or children for whom care is requested must be under the age of six, except during the summer or school breaks. Care shall not be authorized during the hours the child is in school or is home schooled, or if the child is in a two-parent family when the other parent is available to care for the child.

E) Study Time
Child care services may be granted for up to one hour of study time per week for each hour of course credit. When possible, study periods should be arranged around regularly scheduled classes in order to provide a consistent and uninterrupted routine for children in care. Study time shall not be granted to add additional days of care.

4) Relatives (other than parents) who receive child-only TANF or General Assistance (GA) benefits as Representative Payee for children in need of care while they work outside the home.

c) All families must be residents of Illinois.

d) Payment for child care services to eligible parents may begin:

1) if care was provided at the time and all eligibility factors are met, on either:

A) the date of the parent's signature; or

B) one week (seven calendar days) prior to the stamped date of receipt by the Department or its agents, whichever is later; or

2) on the date the child care provider actually begins providing child care services, if the application is received in advance of services being provided and all eligibility factors are met.

e) Eligibility ceases 10 calendar days from the date of the termination notice sent to the parent by the Department or its agents following a determination of ineligibility.

(Source: Amended at 31 Ill. Reg. _____, effective _____)

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NOTICE OF PROPOSED AMENDMENTS

1) Heading of the Part: Water Quality Standards

2) Code Citation: 35 Ill. Adm. Code 302

3)

Section Numbers:	Proposed Action:
302.100	Amend
302.206	Amend
302.APPENDIX D	New Section

4) Statutory Authority: Implementing Sections 11(b) and 13 and authorized by Section 27 of the Environmental Protection Act [415 ILCS 5/11(b), 13, and 27]

5) A Complete Description of the Subjects and Issues Involved: For a more detailed discussion of these amendments, see the Board's July 12, 2007 opinion and order in docket R04-25: In the Matter of: Proposed Amendments to Dissolved Oxygen Standard 35 Ill. Adm. Code 302.206. This rulemaking proposes amendments to the Board's general use water quality standard for dissolved oxygen or "DO". The Board's first-notice amendments are based on aspects of both the proposal filed by the Illinois Association of Wastewater Agencies (IAWA), and the joint proposal later filed by the Illinois Department of Natural Resources (DNR) and the Illinois Environmental Protection Agency (Agency). Further, the amendments proposed for first notice are consistent with the National Criteria Document or "NCD" for DO of the United States Environmental Protection Agency (USEPA), Ambient Aquatic Life Water Quality Criteria for Dissolved Oxygen (Freshwater) (USEPA, Chapman 1986).

This proposal for first notice includes a two-season numeric DO standard with values based on daily minima and 7- and 30-day averages. The "early life stages" season of the proposed two-season numeric DO standard would run from March 1st through July 31st. The egg, embryo, larval, and recently-hatched juvenile life stages of fish are more sensitive to low DO concentrations than later juvenile and adult stages. Additionally, the proposal designates stream segments, approximately 8% of general use stream miles in Illinois, to receive "enhanced" numeric dissolved oxygen standards to protect DO-sensitive fish and macroinvertebrate species present in meaningful amounts. The proposal also includes a narrative DO standard to protect quiescent and isolated sectors of general use waters.

The first-notice proposal is expected to significantly improve the current DO standard by taking into account the varied DO requirements of aquatic communities and the diverse

range of natural aquatic conditions present across Illinois, allowing both public and private resources to be focused on those waters most impacted by low DO.

6) Published studies or reports, and sources of underlying data, used to compose this rulemaking:

Allan, J. D. and L. B. Johnson. 1997. Catchment-scale analysis of aquatic ecosystems. Freshwater Biology 37:107-111.

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Becker, G. C. 1983. Fishes of Wisconsin. The University of Wisconsin Press, Madison, Wisconsin.

Chen, Li-Yen, A. G. Heath, and R. J. Neves. 2001. Comparison of oxygen consumption in freshwater mussels (Unionidae) from different habitats during declining dissolved oxygen concentration. Hydrobiologia 450:209-214.

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Hilsenhoff, W . L. 1977. Use of arthropods to evaluate water quality of streams. Technical Bulletin Number 100. Wisconsin Department of Natural Resources, Madison, Wisconsin.

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Johnson, P. M., A. E. Liner, S. W. Golladay, and W. K. Michener. 2001. Effects of drought on freshwater mussels and instream habitat in Coastal Plain tributaries of the Flint River, southwest Georgia (July-October, 2000). Final Report, presented to The Nature Conservancy, Apalachicola River and Bay Project, http://Wwwjonesctr.org/research/aquatics-research/final report2.pdf

Michigan Department of Natural Resources (Michigan DNR). 2004. Black bass fishing seasons in Michigan: background, research review, and recommendations. Michigan Department of Natural Resources, Fisheries Division.

Moore, W. G. 1942. Field studies on the oxygen requirements of certain fresh-water fishes. Ecology 23:319-329.

Omernik, J. M., Abernathy, A. R., and L. M. Male. 1981. Stream nutrient levels and proximity of agricultural and forest land to streams: some relationships. Journal of Soil and Water Conservation 36:227-231.

Pflieger, W. L. 1997. The fishes of Missouri. Conservation Commission of the State of Missouri, Jefferson City, Missouri.

Rankin, E. T. 2004 (draft). Notes on associations between dissolved oxygen and fish and macroinvertebrate assemblages in wadeable Ohio streams. November 12, Center for Applied Bioassessment and Biocriteria, Columbus, Ohio.

Robison, H. W. and T. M. Buchanan. 1988. Fishes of Arkansas. The University of Arkansas Press, Fayetteville, Arkansas.

Sallee, R. D., J. Langein, H. Brown, and J. Ferencak. 1991. Effects of discharge fluctuations on survival of smallmouth bass in the Kankakee River, Illinois. First International Smallmouth Bass Symposium 90-95.

Simon, T. P. and R. Wallus. 2003. Ictaluridae-catfish and madtoms. Vol. 3, in Wallus, Yeager, and Simon. Reproductive biology and early life history of fishes in the Ohio River drainage. Tennessee Valley Authority, Chattanooga, Tennessee.

Simonson, T. 2001. Wisconsin's black bass management plan-Administrative Report No. 54. Wisconsin Department of Natural Resources, Bureau of Fisheries Management and Habitat Protection, Madison, Wisconsin.

Smale, M. A. and C. F. Rabeni. 1995. Hypoxia and hypothermia tolerances of headwater stream fishes. Transactions of the American Fisheries Society 124 :698-710.

Smart, M. M., T. W. Barney, and J. R. Jones. 1981. Watershed impact on stream water quality: a technique for regional assessment. Journal of Soil and Water Conservation 36:297-300.

Smith, P.W. 1979. The fishes of Illinois. University of Illinois Press, Urbana, Illinois.

Truelson, R. L. 1997. Ambient water quality criteria for dissolved oxygen. Prepared pursuant to section 2(e) of the Environmental Management Act, 1981. Water Management Branch, Ministry of Environment, Lands, and Parks, Vancouver, British Columbia.

U.S. Environmental Protection Agency (USEPA). 1986. Ambient aquatic life water quality criteria for dissolved oxygen (freshwater). EPA 440/5-86-003, April 1986, Office of Research and Development, Environmental Research Laboratories, Duluth, Minnesota.

Weber, C. I. 1973. Biological field and laboratory methods for measuring the quality of surface waters and effluents. EPA-670/4-73-001, USEPA, Cincinnati, Ohio.

7) Will this rulemaking replace any emergency rulemaking currently in effect? No

8) Does this rulemaking contain an automatic repeal date? No

9) Does this rulemaking contain incorporations by reference? No

10) Are there any other proposed rulemakings pending on this Part? No

11) Statement of Statewide Policy Objective: This proposed rule does not create or enlarge a State mandate, as defined in Section 3(b) of the State Mandates Act [30 ILCS 805/3(b) (2002)].

12) Time, Place, and Manner in which interested persons may comment on this proposed rulemaking: The Board will accept written public comment on this proposal for 45 days after the date of publication in the *Illinois Register*. Comments should reference Docket R04-25 and be addressed to:

Clerk's Office
Illinois Pollution Control Board
100 W. Randolph St., Suite 11-500
Chicago, IL 60601

Interested persons may request copies of the Board's opinion and order by calling the Clerk's office at 312-814-3620, or may download copies from the Board's Web site at www.ipcb.state.il.us.

For more information contact hearing officer Richard McGill at 312/814-6983 or email at mcgillr@ipcb.state.il.us.

13) Initial Regulatory Flexibility Analysis:

POLLUTION CONTROL BOARD

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A) Types of small businesses, small municipalities and not for profit corporations affected: The proposed amendments could impact any small business, small municipality, or not-for-profit corporation that may discharge into the waters of Illinois. This proposal was originally filed with the Board by IAWA to update the Board's general use water quality standard for dissolved oxygen in response to concerns of its member wastewater treatment facilities. In nearly every instance, the first-notice proposal is expected to be less restrictive than the current dissolved oxygen standard for general use waters.

B) Reporting, bookkeeping or other procedures required for compliance: The proposed amendments do not add any new reporting or recordkeeping requirement beyond those in existing regulations.

C) Types of Professional skills necessary for compliance: No professional skills beyond those currently required by the existing water pollution regulations will be required.

14) Regulatory Agenda on which this rulemaking was summarized: July 2007

The full text of the Proposed Amendments begins on the next page:

POLLUTION CONTROL BOARD

NOTICE OF PROPOSED AMENDMENTS

TITLE 35: ENVIRONMENTAL PROTECTION
SUBTITLE C: WATER POLLUTION
CHAPTER I: POLLUTION CONTROL BOARD

PART 302
WATER QUALITY STANDARDS

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302.101 Scope and Applicability
302.102 Allowed Mixing, Mixing Zones and ZIDs
302.103 Stream Flows
302.104 Main River Temperatures
302.105 Antidegradation

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302.520 Regulation and Designation of Bioaccumulative Chemicals of Concern (BCCs)
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302.565 Determining the Lake Michigan Basin Chronic Aquatic Life Toxicity Criterion (LMCATC) or the Lake Michigan Basin Chronic Aquatic Life Toxicity Value (LMCATV)
302.570 Procedures for Deriving Bioaccumulation Factors for the Lake Michigan Basin
302.575 Procedures for Deriving Tier I Water Quality Criteria and Values in the Lake Michigan Basin to Protect Wildlife
302.580 Procedures for Deriving Water Quality Criteria and Values in the Lake Michigan Basin to Protect Human Health – General
302.585 Procedures for Determining the Lake Michigan Basin Human Health Threshold Criterion (LMHHTC) and the Lake Michigan Basin Human Health Threshold Value (LMHHTV)
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302.615 Determining the Acute Aquatic Toxicity Criterion – Toxicity Independent of Water Chemistry
302.618 Determining the Acute Aquatic Toxicity Criterion – Toxicity Dependent on Water Chemistry
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302.654 Determining the Risk Associated Intake
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302.658 Stream Flow for Application of Human Nonthreshold Criterion
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302.666 Utilizing the Bioconcentration Factor
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302.APPENDIX C Maximum total ammonia nitrogen concentrations allowable for certain combinations of pH and temperature
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302.TABLE C Temperature and pH-Dependent Values of the CS (Chronic Standard) for Fish Early Life Stages Present
302.APPENDIX D Section 302.206(d): Stream Segments for Enhanced Dissolved Oxygen Protection

AUTHORITY: Implementing Section 13 and authorized by Sections 11(b) and 27 of the Environmental Protection Act [415 ILCS 5/13, 11(b), and 27].

SOURCE: Filed with the Secretary of State January 1, 1978; amended at 2 Ill. Reg. 44, p. 151, effective November 2, 1978; amended at 3 Ill. Reg. 20, p. 95, effective May 17, 1979; amended at 3 Ill. Reg. 25, p. 190, effective June 21, 1979; codified at 6 Ill. Reg. 7818; amended at 6 Ill. Reg. 11161, effective September 7, 1982; amended at 6 Ill. Reg. 13750, effective October 26, 1982; amended at 8 Ill. Reg. 1629, effective January 18, 1984; peremptory amendments at 10 Ill. Reg. 461, effective December 23, 1985; amended at R87-27 at 12 Ill. Reg. 9911, effective May 27, 1988; amended at R85-29 at 12 Ill. Reg. 12082, effective July 11, 1988; amended in R88-1 at 13 Ill. Reg. 5998, effective April 18, 1989; amended in R88-21(A) at 14 Ill. Reg. 2899, effective February 13, 1990; amended in R88-21(B) at 14 Ill. Reg. 11974, effective July 9, 1990; amended in R94-1(A) at 20 Ill. Reg. 7682, effective May 24, 1996; amended in R94-1(B) at 21 Ill. Reg. 370, effective December 23, 1996; expedited correction at 21 Ill. Reg. 6273, effective December 23, 1996; amended in R97-25 at 22 Ill. Reg. 1356, effective December 24, 1997; amended in R99-8 at 23 Ill. Reg. 11249, effective August 26, 1999; amended in R01-13 at 26 Ill. Reg. 3505, effective February 22, 2002; amended in R02-19 at 26 Ill. Reg. 16931, effective November 8, 2002; amended in R02-11 at 27 Ill. Reg. 166, effective December 20, 2002; amended in R04-21 at 30 Ill. Reg. 4919, effective March 1, 2006; amended in R04-25 at 31 Ill. Reg. _____, effective _____.

SUBPART A: GENERAL WATER QUALITY PROVISIONS

Section 302.100 Definitions

Unless otherwise specified, the definitions of the Environmental Protection Act (Act) [415 ILCS 5] and 35 Ill. Adm. Code 301 apply to this Part. As used in this Part, each of the following definitions has the specified meaning.

"Acute Toxicity" means the capacity of any substance or combination of substances to cause mortality or other adverse effects in an organism resulting from a single or short-term exposure to the substance.

"Adverse Effect" means any gross or overt effect on an organism, including but not limited to reversible histopathological damage, severe convulsions, irreversible functional impairment and lethality, as well as any non-overt effect on an organism resulting in functional impairment or pathological lesions which may affect the performance of the whole organism, or which reduces an organism's ability to respond to an additional challenge.

"Chronic Toxicity" means the capacity of any substance or combination of substances to cause injurious or debilitating effects in an organism which result

from exposure for a time period representing a substantial portion of the natural life cycle of that organism, including but not limited to the growth phase, the reproductive phases or such critical portions of the natural life cycle of that organism.

"Criterion" means the numerical concentration of one or more toxic substances derived in accordance with the procedures in Subpart F of this Part which, if not exceeded, would assure compliance with the narrative toxicity standard of Section 302.210 of this Part.

"Early Life Stages" of fish means the pre-hatch embryonic period, the post-hatch free embryo or yolk-sac fry, and the larval period, during which the organism feeds. Juvenile fish, which are anatomically similar to adults, are not considered an early life stage.

"Hardness" means a water quality parameter or characteristic consisting of the sum of calcium and magnesium concentrations expressed in terms of equivalent milligrams per liter as calcium carbonate. Hardness is measured in accordance with methods specified in 40 CFR 136, incorporated by reference in 35 Ill. Adm. Code 301.106.

"Mixing Zone" means a portion of the waters of the State identified as a region within which mixing is allowed pursuant to Section 302.102(d) of this Part.

"Thermocline" means the plane of maximum rate of decrease of temperature with respect to depth in a thermally stratified body of water.

"Total Residual Chlorine" or "TRC" means those substances which include combined and uncombined forms of both chlorine and bromine and which are expressed, by convention, as an equivalent concentration of molecular chlorine. TRC is measured in accordance with methods specified in 40 CFR 136, incorporated by reference in 35 Ill. Adm. Code 301.106.

"Toxic Substance" means a chemical substance that causes adverse effects in humans, or in aquatic or terrestrial animal or plant life. Toxic substances include, but are not limited to, those substances listed in 40 CFR 302.4, incorporated by reference in 35 Ill. Adm. Code 301.106, or any "chemical substance" as defined by the Illinois Chemical Safety Act [430 ILCS 45]

"ZID" or "Zone of Initial Dilution" means a portion of a mixing zone, identified pursuant to Section 302.102(e) of this Part, within which acute toxicity standards need not be met.

(Source: Amended at 31 Ill. Reg. _____, effective _____)

SUBPART B: GENERAL USE WATER QUALITY STANDARDS

Section 302.206 Dissolved Oxygen

General use waters must maintain dissolved oxygen concentrations at or above the values contained in subsections (a), (b) and (c) of this Section. ~~Dissolved oxygen (STORET number 00300) shall not be less than 6.0 mg/1 during at least 16 hours of any 24 hour period, nor less than 5.0 mg/1 at any time.~~

a) General use waters at all locations must maintain sufficient dissolved oxygen concentrations to prevent offensive conditions as required in Section 302.203 of this Part. Quiescent and isolated sectors of General Use waters including but not limited to wetlands, sloughs, backwaters and waters below the thermocline in lakes and reservoirs must be maintained at sufficient dissolved oxygen concentrations to support their natural ecological functions and resident aquatic communities.

b) Except in those waters identified in Appendix D of this Part, the dissolved oxygen concentration in the main body of all streams, in the water above the thermocline of thermally stratified lakes and reservoirs, and in the entire water column of unstratified lakes and reservoirs must not be less than the following:

1) During the period of March through July,

A) 5.0 mg/L at any time; and

B) 6.0 mg/L as a daily mean averaged over 7 days.

2) During the period of August through February,

A) 3.5 mg/L at any time;

B) 4.0 mg/L as a daily minimum averaged over 7 days; and

C) 5.5 mg/L as a daily mean averaged over 30 days.

c) The dissolved oxygen concentration in all sectors within the main body of all streams identified in Appendix D of this Part must not be less than:

1) During the period of March through July,

A) 5.0 mg/L at any time; and

B) 6.25 mg/L as a daily mean averaged over 7 days.

2) During the period of August through February,

A) 4.0 mg/L at any time;

B) 4.5 mg/L as a daily minimum averaged over 7 days; and

C) 6.0 mg/L as a daily mean averaged over 30 days.

d) Assessing attainment of dissolved oxygen mean and minimum values.

1) Daily mean is the arithmetic mean of dissolved oxygen values measured in a single 24-hour calendar day.

2) Daily minimum is the minimum dissolved oxygen value as measured in a single 24-hour calendar day.

3) The measurements of dissolved oxygen used to determine attainment or lack of attainment with any of the dissolved oxygen standards in this Section must assure daily minima and daily means that represent the true daily minima and daily means.

4) The dissolved oxygen value used in calculating or determining any daily mean or daily minimum should not exceed the air-equilibrated value.

5) Daily minimum averaged over 7 days is the arithmetic mean of daily minimum dissolved oxygen values from the current and previous 6 calendar days.

6) Daily mean averaged over 7 days is the arithmetic mean of daily mean dissolved oxygen values from the current and previous 6 calendar days.

7) Daily mean averaged over 30 days is the arithmetic mean of daily mean dissolved oxygen values from the current and previous 29 calendar days.

(Source: Amended at 31 Ill. Reg. _____, effective _____)

Section 302.APPENDIX D Section 302.206(d): Stream Segments for Enhanced Dissolved Oxygen Protection

BASIN NAME

Segment Name

Segment No.

End Points		Latitude	Longitude	COUNTY
Illinois				
Aux Sable Creek				
239				
	start	41.3982125891033	-88.3307365155966	GRUNDY
	end	41.5221610266554	-88.3153074461322	KENDALL
Baker Creek				
123				
	start	41.0993159446094	-87.833779044559	KANKAKEE
	end	41.1187483257075	-87.7916507082604	KANKAKEE
Baptist Creek				
160				
	start	40.5172643895406	-90.9781701980636	HANCOCK
	end	40.5217773790395	-90.9703232423026	HANCOCK
Barker Creek				
170				
	start	40.4730175690641	-90.3623822544051	FULTON
	end	40.4505102531327	-90.423698306895	FULTON
Battle Creek				
196				
	start	41.791467372356	-88.6440656199133	DE KALB
	end	41.8454435074814	-88.6580317835588	DE KALB
Big Bureau Creek				
209				

	start	41.2403303426443	-89.3778305139628	BUREAU
	end	41.6599418992971	-89.0880711727354	LEE
Big Rock Creek				
275				
	start	41.6325949399571	-88.5379727020413	KENDALL
	end	41.7542831812644	-88.5621629654129	KANE
Blackberry Creek				
271				
	start	41.6432480686252	-88.451129393594	KENDALL
	end	41.7663693677829	-88.3855968808499	KANE
Boone Creek				
284				
	start	42.3430701828297	-88.2604646456881	MCHENRY
	end	42.3116813126792	-88.3284649937798	MCHENRY
Buck Creek				
225				
	start	41.4305449377211	-88.7732713228626	LA SALLE
	end	41.4508806057478	-88.919966063547	LA SALLE
403				
	start	40.6513984442885	-88.8660496976016	MCLEAN
	end	40.6757825960266	-88.8490439132056	MCLEAN
Camp Creek				
116				
	start	41.0119168530464	-89.7317034650143	STARK
	end	41.0202988179758	-89.6817209218761	STARK
168				
	start	40.2936155016035	-90.7791785207262	MCDONOUGH
	end	40.3985161419285	-90.5089903510732	MCDONOUGH
Camp Run				
115				
	start	41.0119168530464	-89.7317034650143	STARK

	end	41.0575944852479	-89.6822685234528	STARK
Cantway Slough				
250				
	start	41.1654521279715	-87.6179423055771	KANKAKEE
	end	41.1204910206261	-87.6018847740212	KANKAKEE
Cedar Creek				
164				
	start	40.4187924503946	-91.0119249544251	HANCOCK
	end	40.4320989747514	-90.9816512014458	HANCOCK
Central Ditch				
17				
	start	40.2466345144431	-89.8605138200519	MASON
	end	40.259146892407	-89.8331744969958	MASON
Clear Creek				
70				
	start	40.2358631766436	-89.1715114085864	LOGAN
	end	40.2817523596784	-89.2105606026356	MCLEAN
Coal Creek				
173				
	start	40.6458316286298	-90.2773695191768	FULTON
	end	40.6911917975894	-90.0990104026141	FULTON
Collins Run				
243				
	start	41.4219631544372	-88.3508108111242	GRUNDY
	end	41.4172036201222	-88.3955434158999	GRUNDY
Conover Branch				
184				
	start	39.8376993452498	-90.1465720267561	MORGAN
	end	39.8696939232648	-90.1234898871846	MORGAN
Coon Creek				
60				

	start	40.1076562155273	-89.0130117597621	DEWITT
	end	40.1755351290733	-88.8857086715202	DEWITT
Coop Branch				
31				
	end	39.2042878811665	-90.0972130791043	MACOUPIN
	end	39.1194481626997	-89.9878509202749	MACOUPIN
Coopers Defeat Creek				
114				
	start	41.1557502062867	-89.748162019475	STARK
	end	41.1485959333575	-89.6944246708098	STARK
Copperas Creek				
88				
	start	40.4856512052475	-89.8867983078194	FULTON
	end	40.549513691198	-89.9011907117391	FULTON
Court Creek				
122				
	start	40.9184191403691	-90.1108008628507	KNOX
	end	40.9349919352638	-90.2673514797552	KNOX
Cox Creek				
177				
	start	40.0231674243157	-90.1158780774246	CASS
	end	39.9657957063914	-90.0180644049351	CASS
Crane Creek				
174				
	start	40.1328714038267	-89.9709414534257	MENARD
	end	40.2466345144431	-89.8605138200519	MASON
Crow Creek				
102				
	start	40.9323207251964	-89.4264477600798	MARSHALL
	end	40.9663161180876	-89.2558617294218	MARSHALL
Deer Creek				

59				
	start	40.117679723776	-89.3801215076251	LOGAN
	end	40.1915602627115	-89.1582023776838	LOGAN
Dickerson Slough				
421				
	start	40.3597968706068	-88.3225685158141	CHAMPAIGN
	end	40.4568389800294	-88.3442742579475	FORD
Drummer Creek				
423				
	start	40.37389931547	-88.3480753423386	CHAMPAIGN
	end	40.479101489993	-88.388698487066	FORD
Dry Fork				
35				
	start	39.1989703827155	-89.9609795725648	MACOUPIN
	end	39.1445756951412	-89.8876581181152	MACOUPIN
Du Page River				
268				
	start	41.4988385272507	-88.2166248594859	WILL
	end	41.7019525201778	-88.1476209409341	WILL
Eagle Creek				
392				
	start	41.1360015419764	-88.8528525904771	LA SALLE
	end	41.1291172842462	-88.8664977236647	LA SALLE
East Aux Sable Creek				
240				
	start	41.5221610266554	-88.3153074461322	KENDALL
	end	41.6231669397764	-88.2938779285952	KENDALL
East Branch Big Rock Creek				
277				
	start	41.7542830239271	-88.5621632556731	KANE
	end	41.8161922949561	-88.6002917634599	KANE

East Branch Copperas Creek				
47				
	start	40.549514632509	-89.901189903351	FULTON
	end	40.6583152735498	-89.8516717710553	PEORIA
East Fork La Moine River				
167				
	start	40.3962156185095	-90.9339386121768	HANCOCK
	end	40.4506930058171	-90.758703782814	MCDONOUGH
East Fork Mazon River				
256				
	start	41.1872307009926	-88.2731640461448	GRUNDY
	end	41.0815161304671	-88.3093601699244	LIVINGSTON
East Fork Spoon River				
110				
	start	41.2158736312898	-89.6870256054763	STARK
	end	41.2603216291895	-89.7311074496692	BUREAU
Easterbrook Drain				
410				
	start	40.3687232740908	-88.5787269955356	MCLEAN
	end	40.3909243275675	-88.5484031360558	MCLEAN
Exline Slough				
252				
	start	41.1187483257075	-87.7916507082604	KANKAKEE
	end	41.3377194296138	-87.674538578544	WILL
Fargo Run				
94				
	start	40.8110626738718	-89.7625906815013	PEORIA
	end	40.7936211492847	-89.7147157689809	PEORIA
Ferson Creek				
281				
	start	41.9275380999085	-88.3177738518806	KANE

	end	41.9518312998438	-88.3965138071814	KANE
Fitch Creek				
131				
	start	41.0629732421579	-89.9929808862433	KNOX
	end	41.1048465021615	-90.0171275726119	KNOX
Forked Creek				
265				
	start	41.312634893655	-88.1518349597477	WILL
	end	41.4208599921871	-87.8221168060732	WILL
Forman Creek				
129				
	start	41.0920068762041	-90.1229512077171	KNOX
	end	41.061779692349	-90.1373931430424	KNOX
Fourmile Grove Creek				
232				
	start	41.5880621752377	-89.0154533767497	LA SALLE
	end	41.6281572065102	-89.0480036727754	LEE
Fox Creek				
121				
	start	41.2158736312898	-89.6870256054763	STARK
	end	41.2178841576744	-89.6378797955943	BUREAU
Fox River				
270				
	start	41.6177003859476	-88.5558384703467	KENDALL
	end	41.7665361019038	-88.3100243828453	KANE
Friends Creek				
56				
	start	39.9296881580789	-88.7753341828841	MACON
	end	40.0511150621524	-88.756810733868	MACON
Furrer Ditch				
175				

	start	40.259146892407	-89.8331744807195	MASON
	end	40.256856262248	-89.8235353908665	MASON
Gooseberry Creek				
138				
	start	41.0815161304671	-88.3093601699244	LIVINGSTON
	end	41.0229178273291	-88.3433997610298	LIVINGSTON
181				
	start	41.2273512263311	-88.3737634512576	GRUNDY
	end	41.1567969821084	-88.3954921510714	GRUNDY
Grindstone Creek				
169				
	start	40.2936155016035	-90.7791785207262	MCDONOUGH
	end	40.3128991202966	-90.6514786739624	MCDONOUGH
Hall Ditch				
176				
	start	40.214043063866	-89.8947856138658	MASON
	end	40.1996396083582	-89.8430392085184	MASON
Hallock Creek				
101				
	start	40.9330251540704	-89.523027406387	PEORIA
	end	40.9162496002415	-89.5368879858621	PEORIA
Haw Creek				
125				
	start	40.8575772861862	-90.2335091570553	KNOX
	end	40.9174343445877	-90.3387634753254	KNOX
Henline Creek				
401				
	start	40.5867014223785	-88.6971328093932	MCLEAN
	end	40.6247936449316	-88.6315733675586	MCLEAN
Henry Creek				
100				

	start	40.932455717876	-89.5256512687818	PEORIA
	end	40.9472322228041	-89.5711427004422	PEORIA
Hermon Creek				
126				
	start	40.7818347201379	-90.2738699961108	KNOX
	end	40.7628476930817	-90.3372052339614	KNOX
Hickory Creek				
244				
	start	41.5038289458964	-88.0990240076033	WILL
	end	41.4935392717868	-87.8108342251738	WILL
Hickory Grove Ditch				
87				
	start	40.4870721779667	-89.7285827911466	TAZEWELL
	end	40.4136575635669	-89.7349507058786	MASON
Hickory Run				
93				
	start	40.8217198390551	-89.7449749384213	PEORIA
	end	40.8581447502391	-89.7622130910013	PEORIA
Hillsbury Slough				
416				
	start	40.3453953438371	-88.3035309970523	CHAMPAIGN
	end	40.3928682378873	-88.2265028280313	CHAMPAIGN
Hodges Creek				
34				
	start	39.2630316914552	-90.1858200381692	GREENE
	end	39.2801974743086	-90.1528766403572	GREENE
Hurricane Creek				
44				
	start	39.449376470161	-90.5400508230403	GREENE
	end	39.4781872332274	-90.4508986197452	GREENE
Illinois River				

236				
	start	41.3255740245957	-88.9910230492306	LA SALLE
	end	41.3986780470527	-88.2686499362959	GRUNDY
Indian Creek				
120				
	start	40.988610901184	-89.8221496834014	STARK
	end	41.2003389912185	-89.9349435285117	HENRY
182				
	start	39.8785447641605	-90.3782080959549	CASS
	end	39.8234731084942	-90.103743390331	MORGAN
224				
	start	41.7480730242898	-88.8741562924388	DE KALB
	end	41.7083887626958	-88.9437996894049	LEE
226				
	start	41.4400734113231	-88.7627018786422	LA SALLE
	end	41.7377348577433	-88.8557728844589	DE KALB
396				
	start	40.7701181840118	-88.4858209632899	LIVINGSTON
	end	40.6469799222669	-88.4812665778082	LIVINGSTON
Iroquois River				
253				
	start	41.0739205590002	-87.8152251833303	KANKAKEE
	end	40.9614905075375	-87.8149010739444	IROQUOIS
447				
	start	40.7817769095357	-87.7532807121524	IROQUOIS
	end	40.8174648935578	-87.5342555764515	IROQUOIS
Jack Creek				
109				
	start	41.1283656948767	-89.7699479168181	STARK
	end	41.150467875432	-89.8374616586589	STARK
Jackson Creek				

246				
	start	41.4325013563553	-88.1725611633353	WILL
	end	41.4638503957577	-87.9160301224816	WILL
Joes Creek				
33				
	start	39.2801974743086	-90.1528766403572	GREENE
	end	39.3757180969001	-90.0772968234561	MACOUPIN
Johnny Run				
258				
	start	41.2826709079541	-88.3633805819326	GRUNDY
	end	41.0807507198308	-88.5801638050665	LIVINGSTON
Jordan Creek				
266				
	start	41.3044458242397	-88.1279087273328	WILL
	end	41.3077177643453	-88.1188984685001	WILL
Judd Creek				
106				
	start	41.089645284216	-89.1847595119809	MARSHALL
	end	41.0429807674449	-89.1339049242164	MARSHALL
Kankakee River				
248				
	start	41.3923135096469	-88.2590124225285	GRUNDY
	end	41.1660752568715	-87.526360971907	KANKAKEE
Kickapoo Creek				
57				
	start	39.9932216924528	-88.8083252484687	MACON
	end	39.9987405799186	-88.8205170598483	MACON
65				
	start	40.1286520491088	-89.4532728967436	LOGAN
	end	40.4376592310728	-88.8667409562596	MCLEAN
92				

	start	40.6548826785105	-89.6134608723157	TAZEWELL
	end	40.9170471944911	-89.6577393908301	PEORIA
Kings Mill Creek				
83				
	start	40.4558745105979	-89.1642930044364	MCLEAN
	end	40.509184986927	-89.0937965002854	MCLEAN
La Harpe Creek				
159				
	start	40.4678428297867	-91.0424167497572	HANCOCK
	end	40.5172643895406	-90.9781701980636	HANCOCK
La Moine River				
158				
	start	40.3320849972693	-90.8997234923388	MCDONOUGH
	end	40.5923258750258	-91.0177293656635	HANCOCK
Lake Fork				
61				
	start	40.0837107988142	-89.3969397975165	LOGAN
	end	39.9367293000733	-89.2343282851812	LOGAN
Langan Creek				
254				
	start	40.9614905075375	-87.8149010739444	IROQUOIS
	end	40.9432018898477	-88.0465558527168	IROQUOIS
Lime Creek				
214				
	start	41.4515003790233	-89.5271752648714	BUREAU
	end	41.4951141474998	-89.456554884734	BUREAU
Little Indian Creek				
183				
	start	39.8355964564522	-90.1231971747256	MORGAN
	end	39.8658175367056	-90.0423591294145	MORGAN
227				

	start	41.5091299863247	-88.7725444056074	LA SALLE
	end	41.749433980972	-88.8141442269697	DE KALB
Little Kickapoo Creek				
67				
	start	40.3336625070255	-88.9736094275975	MCLEAN
	end	40.394785197415	-88.9473142490326	MCLEAN
Little Mackinaw River				
82				
	start	40.4423190352496	-89.4617848276975	TAZEWELL
	end	40.4481261917524	-89.4329939054056	TAZEWELL
Little Rock Creek				
274				
	start	41.6345548769785	-88.5384723455853	KENDALL
	end	41.7895688619816	-88.6981590581244	DE KALB
Little Sandy Creek				
107				
	start	41.0912632622075	-89.2247552498617	MARSHALL
	end	41.125352501365	-89.1758716886846	PUTNAM
Little Senachwine Creek				
99				
	start	40.9533145540839	-89.5292433956921	PEORIA
	end	41.0084439145565	-89.5499765139822	MARSHALL
Little Vermilion River				
233				
	start	41.3237602050852	-89.0811945323001	LA SALLE
	end	41.5760289435671	-89.0829047126545	LA SALLE
Lone Tree Creek				
418				
	start	40.3750682121535	-88.3819688457729	CHAMPAIGN
	end	40.3145980401842	-88.4738655755984	MCLEAN
Long Creek				

163				
	start	40.4466427913955	-91.0499607552846	HANCOCK
	end	40.4297652043359	-91.1507109600489	HANCOCK
Long Point Creek				
68				
	start	40.2755311999445	-89.0786438507327	DEWITT
	end	40.2549604211821	-88.9826285651361	DEWITT
394				
	start	41.038177645276	-88.7908409579793	LIVINGSTON
	end	41.0018214714974	-88.8534349418926	LIVINGSTON
Mackinaw River				
397				
	start	40.5796794158534	-89.2813445945626	TAZEWELL
	end	40.5649627479232	-88.478822725546	MCLEAN
Macoupin Creek				
32				
	start	39.1989703827155	-89.9609795725648	MACOUPIN
	start	39.2121253451487	-90.2312084410337	JERSEY
Madden Creek				
413				
	start	40.0943580002069	-88.5400649488702	PIATT
	end	40.2109635906658	-88.4943738561926	PIATT
Masters Creek				
220				
	start	41.4976109383336	-89.4125473607076	BUREAU
	end	41.5439000049343	-89.421988392756	BUREAU
Masters Fork				
217				
	start	41.4531024225454	-89.4290492805799	BUREAU
	end	41.5702310455498	-89.3821188149649	BUREAU
Mazon River				

257				
	start	41.3086768327676	-88.3389845675056	GRUNDY
	end	41.1872307009926	-88.2731640461448	GRUNDY
Mendota Creek				
234				
	start	41.5281666288805	-89.1041764154672	LA SALLE
	end	41.5282367334928	-89.1224368860589	LA SALLE
Middle Branch of Copperas Creek				
90				
	start	40.549514632509	-89.901189903351	FULTON
	end	40.5980896362772	-89.9368482699851	FULTON
Middle Creek				
165				
	start	40.3957329294144	-90.9741776721721	HANCOCK
	end	40.3888894030526	-91.0072502737366	HANCOCK
Mill Creek				
494				
	start	41.8213649020421	-88.3222376599138	KANE
	end	41.9231053361497	-88.4419826012614	KANE
Mole Creek				
390				
	start	41.0193910577853	-88.8019375580673	LIVINGSTON
	end	40.9109452909954	-88.9263176124884	LIVINGSTON
Morgan Creek				
272				
	start	41.6481172046369	-88.4151168308869	KENDALL
	end	41.6530911245692	-88.3631669287476	KENDALL
Mud Creek				
449				
	start	40.637099482441	-87.5885960450541	IROQUOIS
	end	40.6100172186722	-87.5261312404789	IROQUOIS

Mud Run

117

start	41.0092425694765	-89.7790957399812	STARK
end	40.9876287937001	-89.6785472090663	STARK

Murray Slough

259

start	41.2428845425989	-88.3615508333781	GRUNDY
end	41.054741775769	-88.5825975362008	LIVINGSTON

Nettle Creek

237

start	41.3559056532822	-88.4326806825019	GRUNDY
end	41.3989525138118	-88.5519708865374	GRUNDY

Nippersink Creek

285

start	42.403479031235	-88.1904263022916	LAKE
end	42.408321560969	-88.341299199739	MCHENRY

289

start	42.3885864249526	-88.3641081665149	MCHENRY
end	42.4692291197455	-88.4764236384547	MCHENRY

North Branch Crow Creek

103

start	40.9663161180876	-89.2558617294218	MARSHALL
end	41.0005549578781	-89.1943061363378	MARSHALL

North Branch Nippersink Creek

286

start	42.4376632559979	-88.2872504317539	MCHENRY
end	42.4945866793007	-88.3294075716268	MCHENRY

North Creek

119

start	40.9486975483619	-89.7633680090807	PEORIA
end	40.9421533616142	-89.7281078793964	PEORIA

North Fork Lake Fork				
62				
	start	39.9367293000733	-89.2343282851812	LOGAN
	end	40.0523211989442	-89.0999303242614	DEWITT
North Fork Salt Creek				
71				
	start	40.2675598120912	-88.7867164044023	DEWITT
	end	40.3620541452609	-88.7204600533309	MCLEAN
Otter Creek				
171				
	start	40.2161621556914	-90.164317977292	FULTON
	end	40.3182822717998	-90.3860609925548	FULTON
279				
	start	41.9619670384069	-88.3574449893747	KANE
	end	41.9903303640688	-88.3568570687618	KANE
393				
	start	41.1611802253124	-88.8310854379729	LA SALLE
	end	41.1541734588026	-88.7148550047115	LA SALLE
Panther Creek				
178				
	start	40.0231674243157	-90.1158780774246	CASS
	end	39.9411115612757	-90.0607356525317	CASS
405				
	start	40.6607941387838	-89.196034413193	WOODFORD
	end	40.8483817762616	-89.0003562591212	WOODFORD
Paw Paw Run				
231				
	start	41.6177945875792	-88.8847204360202	LA SALLE
	end	41.6630271288718	-88.9144064528509	DE KALB
Pike Creek				
216				

	start	41.5121637096396	-89.3366888940457	BUREAU
	end	41.5707857354427	-89.2125163729316	BUREAU
388				
	start	40.8655185113965	-88.7090974772719	LIVINGSTON
	end	40.7989226101833	-88.7756316859923	LIVINGSTON
Pond Creek				
212				
	start	41.3494925800361	-89.5685244208084	BUREAU
	end	41.3541221673156	-89.6001721270724	BUREAU
Poplar Creek				
493				
	start	42.0127893042098	-88.2799278350546	KANE
	end	42.0604682884044	-88.151517184544	COOK
Prairie Creek				
69				
	start	40.2688606116755	-89.1209318708141	DEWITT
	end	40.3183618654781	-89.1150133167993	MCLEAN
79				
	start	40.1610672222447	-89.6159697428554	MASON
	end	40.3105388304102	-89.4819788351989	LOGAN
264				
	start	41.3410818305214	-88.1859963163497	WILL
	end	41.4048430210988	-87.9636949110551	WILL
391				
	start	41.0691920852358	-88.8106812576958	LIVINGSTON
	end	41.0162806406811	-89.0122375626521	LA SALLE
Prairie Creek Ditch				
81				
	start	40.242940205103	-89.5831738921535	LOGAN
	end	40.268603376062	-89.5902703680441	LOGAN
Prince Run				

118				
	start	40.9953442805941	-89.7634490486344	STARK
	end	40.9486975483619	-89.7633680090807	PEORIA
Rob Roy Creek				
495				
	start	41.6340658591268	-88.530902327864	KENDALL
	end	41.7208669225124	-88.4449822691918	KENDALL
Rock Creek				
180				
	start	39.9533586794244	-89.7717217346798	MENARD
	end	39.9192042890665	-89.881417605895	MENARD
251				
	start	41.2029705333006	-87.9860450524621	KANKAKEE
	end	41.2416733683013	-87.9199539652218	KANKAKEE
Rocky Run				
221				
	start	41.2966432755716	-89.5031050607007	BUREAU
	end	41.2892114895079	-89.5271301009319	BUREAU
Rooks Creek				
386				
	start	40.9620056243899	-88.737743684525	LIVINGSTON
	end	40.7615433072922	-88.6752675977812	LIVINGSTON
Salt Creek				
58				
	start	40.1286520491088	-89.4532728967436	LOGAN
	end	40.1404369482862	-88.8817439726269	DEWITT
409				
	start	40.2793653821328	-88.6019348286105	DEWITT
	end	40.3687232740908	-88.5787269955356	MCLEAN
Sandy Creek				
105				

	start	41.1083947129797	-89.3471796913242	PUTNAM
	end	41.0855613697751	-89.0792291942694	MARSHALL
Sangamon River				
408				
	start	40.0056362283258	-88.6286241506431	PIATT
	end	40.4223231153926	-88.67328493366	MCLEAN
Senachwine Creek				
96				
	start	40.929825860388	-89.4632928486271	PEORIA
	end	41.0900318754938	-89.5885134178247	MARSHALL
Short Creek				
162				
	start	40.4611057719393	-91.0582083107674	HANCOCK
	end	40.4682735975769	-91.0704506789577	HANCOCK
Short Point Creek				
389				
	start	40.9883827214271	-88.7830008925065	LIVINGSTON
	end	40.8951301673701	-88.8749997260932	LIVINGSTON
Silver Creek				
111				
	start	41.2185762138697	-89.6793069447094	STARK
	end	41.2431713087936	-89.6494927441058	BUREAU
South Branch Crow Creek				
104				
	start	40.9663161180876	-89.2558617294218	MARSHALL
	end	40.9410075148431	-89.1948285503851	MARSHALL
South Branch Forked Creek				
267				
	start	41.2631372965881	-88.0315238211836	WILL
	end	41.292604367733	-87.9621751169561	KANKAKEE
South Fork Lake Fork				

63				
	start	39.9367293000733	-89.2343282851812	LOGAN
	end	39.9674631778105	-89.0884701339793	MACON
South Fork Vermilion River				
395				
	start	40.7701181840118	-88.4858209632899	LIVINGSTON
	end	40.7234241258087	-88.355790853647	LIVINGSTON
Spoon River				
3				
	start	40.883272448156	-90.0994555125119	KNOX
	end	41.2158736312898	-89.6870256054763	STARK
Spring Creek				
161				
	start	40.5838583294631	-91.0397056763892	HANCOCK
	end	40.595079516268	-91.0572149428165	HANCOCK
166				
	start	40.4506930058171	-90.758703782814	MCDONOUGH
	end	40.5047702003096	-90.7202911238868	MCDONOUGH
223				
	start	41.3114342012759	-89.1969933188526	BUREAU
	end	41.5341774964794	-89.1599030581214	LA SALLE
Stevens Creek				
55				
	start	39.833172054334	-89.008501860042	MACON
	end	39.8725126750168	-88.9902570309468	MACON
Sugar Creek				
76				
	start	40.1505909949415	-89.6335239996087	MENARD
	end	40.3515916252906	-89.1626966142058	MCLEAN
124				
	start	40.9273148603695	-90.1168866799652	KNOX

	end	40.9407150872189	-90.126984172004	KNOX
448				
	start	40.7817769095357	-87.7532807121524	IROQUOIS
	end	40.650106664471	-87.5259225515566	IROQUOIS
Sutphens Run				
228				
	start	41.5813276727649	-88.9196815109252	LA SALLE
	end	41.5940767755281	-89.0434408697488	LA SALLE
Swab Run				
127				
	start	40.8043825531334	-90.0417502151246	KNOX
	end	40.8089204046364	-89.9959890937906	KNOX
Tenmile Creek				
64				
	start	40.1166122038468	-89.0605809659338	DEWITT
	end	40.1573804135529	-88.9870426654374	DEWITT
Timber Creek				
77				
	start	40.3499903738803	-89.1633832938062	MCLEAN
	end	40.3824906556377	-89.0653243216353	MCLEAN
Trim Creek				
249				
	start	41.1679695055755	-87.6275919071884	KANKAKEE
	end	41.3235679470585	-87.6273348723156	WILL
Turkey Creek				
172				
	start	40.5312633037562	-90.2784734138591	FULTON
	end	40.6100168551688	-90.1683886238592	FULTON
402				
	start	40.6346912128201	-88.8256051903746	MCLEAN
	end	40.6636296144043	-88.7848217949076	MCLEAN

Tyler Creek

283

start	42.057069434075	-88.2869209701875	KANE
end	42.0886074301339	-88.3939734393445	KANE

Unnamed Tributary

230

start	41.6008353940091	-88.9239309686064	LA SALLE
end	41.6393800996109	-88.95237726256	LEE

406

start	40.8483817762616	-89.0003562591212	WOODFORD
end	40.8446321845668	-88.9879480330159	WOODFORD

Unnamed Tributary of Big Bureau Creek

222

start	41.2923889187328	-89.4849627504116	BUREAU
end	41.2746773653832	-89.4967232161933	BUREAU

Unnamed Tributary of Coopers Defeat Creek

113

start	41.1485959333575	-89.6944246708098	STARK
end	41.1432423938169	-89.6549152326434	STARK

Unnamed Tributary of Dickerson Slough

422

start	40.4068214049304	-88.3388760698826	FORD
end	40.4286849455119	-88.3118606581845	FORD

Unnamed Tributary of Drummer Creek

425

start	40.430183509928	-88.3944923485681	FORD
end	40.4228198536222	-88.4420280012069	FORD

Unnamed Tributary of East Branch of Copperas Creek

89				
	start	40.59257130763	-89.8385498955685	PEORIA
	start	40.59257130763	-89.8385498955685	PEORIA
Unnamed Tributary of East Fork of Spoon River				
112				
	start	41.1911731339471	-89.6948993736812	STARK
	end	41.1958777466981	-89.6635132189552	STARK
Unnamed Tributary of Indian Creek				
185				
	start	39.8195431621523	-90.231206997871	MORGAN
	end	39.7997709298014	-90.2444898890822	MORGAN
229				
	start	41.5989641246871	-88.913295513256	LA SALLE
	end	41.6212302072922	-88.9971274321449	LA SALLE
Unnamed Tributary of Jackson Creek				
247				
	start	41.4328713295604	-88.0777949404827	WILL
	end	41.4181859202087	-88.0389954976751	WILL
Unnamed Tributary of Johnny Run				
261				
	start	41.1315090714299	-88.5704499691513	GRUNDY
	end	41.1211734141418	-88.5813177275807	GRUNDY
Unnamed Tributary of Kickapoo Creek				
66				
	start	40.4376592310728	-88.8667409562596	MCLEAN
	end	40.4499435649154	-88.7941853627565	MCLEAN
95				
	start	40.843847234267	-89.6598940056171	PEORIA
	end	40.8376970553513	-89.655765678658	PEORIA

Unnamed Tributary of Lone Tree Creek

417

start	40.3145980401842	-88.4738655755984	MCLEAN
end	40.3084681821929	-88.4721825603404	MCLEAN

419

start	40.3200878690807	-88.4758169784284	MCLEAN
end	40.3246054213609	-88.502979969789	MCLEAN

420

start	40.3555955038811	-88.4486860730234	CHAMPAIGN
end	40.3553786361326	-88.4890287857383	MCLEAN

Unnamed Tributary of Mackinaw River

398

start	40.5649627479232	-88.478822725546	MCLEAN
end	40.4956570103387	-88.5106552787079	MCLEAN

399

start	40.558742486097	-88.5447290418444	MCLEAN
end	40.532461937187	-88.5550436512012	MCLEAN

400

start	40.5536214693649	-88.6155771894066	MCLEAN
end	40.5386135050112	-88.6150100834316	MCLEAN

Unnamed Tributary of Masters Creek

219

start	41.5407471962821	-89.4154110620948	BUREAU
end	41.5452528261938	-89.4136798690744	BUREAU

Unnamed Tributary of Masters Fork

218

start	41.510430587881	-89.3900507138719	BUREAU
end	41.6181398940954	-89.2965280984998	LEE

Unnamed Tributary of Nettle Creek

238				
	start	41.4088814108094	-88.5216683950888	GRUNDY
	end	41.4186133676397	-88.5339604493093	GRUNDY
Unnamed Tributary of Nippersink Creek				
255				
	start	42.4692291197455	-88.4764236384547	MCHENRY
	end	42.4695432978934	-88.5110499918451	MCHENRY
288				
	start	42.4176539163554	-88.3444740410368	MCHENRY
	end	42.4179067763647	-88.3502762821058	MCHENRY
290				
	start	42.3969278131381	-88.4109784072142	MCHENRY
	end	42.3875994074602	-88.4491666706176	MCHENRY
Unnamed Tributary of North Fork of Salt Creek				
72				
	start	40.3598944577027	-88.7302360564635	MCLEAN
	end	40.3817246400667	-88.7481607936989	MCLEAN
73				
	start	40.3620541452609	-88.7204600533309	MCLEAN
	end	40.3690272117515	-88.6961244618476	MCLEAN
75				
	start	40.2987649882463	-88.7603546124853	MCLEAN
	end	40.3051172967471	-88.7525145171727	MCLEAN
Unnamed Tributary of Panther Creek				
179				
	start	39.9411115612757	-90.0607356525317	CASS
	end	39.9350887523192	-90.047762075576	CASS
Unnamed Tributary of Pond Creek				
211				

	start	41.3541221673156	-89.6001721270724	BUREAU
	end	41.3352313411595	-89.5875580793812	BUREAU
Unnamed Tributary of Prairie Creek				
78				
	start	40.2086608970772	-89.6103029312127	MASON
	end	40.2239585519289	-89.638616348402	MASON
80				
	start	40.3105388304102	-89.4819788351989	LOGAN
	end	40.3114851545122	-89.4410508250634	LOGAN
Unnamed Tributary of Rooks Creek				
387				
	start	40.7615433072922	-88.6752675977812	LIVINGSTON
	end	40.7348742139519	-88.6985073106457	MCLEAN
Unnamed Tributary of Salt Creek				
412				
	start	40.3090617343957	-88.6002511568763	MCLEAN
	end	40.3165662374132	-88.6011454430269	MCLEAN
Unnamed Tributary of Sandy Creek				
108				
	start	41.0816545465891	-89.0921996326175	MARSHALL
	end	41.0690044849354	-89.0872784559417	MARSHALL
Unnamed Tributary of Sangamon River				
414				
	start	40.2187198550443	-88.3726776422252	CHAMPAIGN
	end	40.207759150969	-88.3556670563292	CHAMPAIGN
415				
	start	40.2618571248343	-88.3804307110291	CHAMPAIGN
	end	40.2604569179243	-88.4076966986332	CHAMPAIGN
Unnamed Tributary of Senachwine Creek				

97				
	start	41.0729094906046	-89.5194162172506	MARSHALL
	end	41.1005615839111	-89.5247542292286	MARSHALL
98				
	start	41.0008160428297	-89.5071527441621	MARSHALL
	end	41.0407981005047	-89.5430844273656	MARSHALL
Unnamed Tributary of Walnut Creek				
130				
	start	41.0811500581416	-90.0632765005186	KNOX
	end	41.0847653353348	-90.0680765817376	KNOX
132				
	start	41.0602585608831	-89.9869046205873	KNOX
	end	41.0721601609241	-89.9735120056073	STARK
133				
	start	41.0262443553352	-89.9515238620326	STARK
	end	41.0340788244836	-89.924721175772	STARK
Unnamed Tributary of West Bureau Creek				
215				
	start	41.4606455355906	-89.5251264675481	BUREAU
	end	41.4958522845312	-89.5472802493082	BUREAU
Unnamed Tributary of West Fork Sugar Creek				
85				
	start	40.3381506914873	-89.2954898975603	TAZEWELL
	end	40.3660114221746	-89.2448498120596	MCLEAN
86				
	start	40.3105145326502	-89.3291625265707	LOGAN
	end	40.3299182729366	-89.3779530037535	TAZEWELL
Valley Run				
241				
	start	41.4172036201222	-88.3955434158999	GRUNDY

	end	41.5039796750174	-88.5041976708714	KENDALL
Vermilion Creek				
235				
	start	41.4768291322914	-89.0571044195371	LA SALLE
	end	41.5338604103044	-89.0473804190906	LA SALLE
Vermilion River				
385				
	start	41.3202746199326	-89.067686548398	LA SALLE
	end	40.8817674383366	-88.6504671722722	LIVINGSTON
Walnut Creek				
128				
	start	40.9597510841493	-89.9769499175619	PEORIA
	end	41.12653217294	-90.2059192933585	KNOX
404				
	start	40.6253040823561	-89.239009045057	WOODFORD
	end	40.7670065190601	-89.3054156233977	WOODFORD
Waubonsie Creek				
273				
	start	41.6864691774875	-88.3543291766866	KENDALL
	end	41.727653072306	-88.2817226140407	KANE
Waupecan Creek				
262				
	start	41.3345412028515	-88.4648617458928	GRUNDY
	end	41.1880870688571	-88.5889392759762	LA SALLE
Welch Creek				
278				
	start	41.7390229211455	-88.5133300234389	KANE
	end	41.7542282081589	-88.4963865174814	KANE
West Branch Big Rock Creek				
276				
	start	41.7542830239271	-88.5621632556731	KANE

	end	41.791467372356	-88.6440656199133	DE KALB
West Branch Drummer Creek				
424				
	start	40.4348513301682	-88.3934764271309	FORD
	end	40.4490333768479	-88.4056995893214	FORD
West Branch Du Page River				
269				
	start	41.7019525201778	-88.1476209409341	WILL
	end	41.7799425869794	-88.1712650214772	DU PAGE
West Branch of Easterbrook Drain				
411				
	start	40.3633709579832	-88.5816306009141	MCLEAN
	end	40.3762064931712	-88.5843753634505	MCLEAN
West Branch of Horse Creek				
263				
	start	41.2492485076225	-88.1312055809841	WILL
	end	41.0019131557324	-88.1364114459172	KANKAKEE
West Branch of Lamarsh Creek				
91				
	start	40.5615978513207	-89.6991824445749	PEORIA
	end	40.640281675188	-89.7388615248892	PEORIA
West Branch Panther Creek				
407				
	start	40.7528335084236	-89.1030067348099	WOODFORD
	end	40.7954060105963	-89.1900600098668	WOODFORD
West Bureau Creek				
213				
	start	41.3209910742583	-89.5195916727401	BUREAU
	end	41.478267808168	-89.5152211006131	BUREAU
West Fork Mazon River				

260

start	41.2530670781541	-88.3508667933585	GRUNDY
end	41.0302502359071	-88.5226194555857	LIVINGSTON

West Fork Salt Creek

74

start	40.317360196629	-88.7559599297755	MCLEAN
end	40.3372561693307	-88.8039670869984	MCLEAN

West Fork Sugar Creek

84

start	40.2844404292499	-89.332075650855	LOGAN
end	40.4558745105979	-89.1642930044364	MCLEAN

Wolf Creek

497

start	41.1540042913791	-88.8612912917747	LA SALLE
end	41.1611802253124	-88.8310854379729	LA SALLE

Kaskaskia

Bearcat Creek

37

start	39.0121682814832	-89.5317265036074	BOND
end	39.0568357269204	-89.4889786056249	MONTGOMERY

Becks Creek

45

start	39.1565938305703	-88.9491156388975	FAYETTE
end	39.3602481794208	-89.0227919838743	SHELBY

Brush Creek

39

start	39.1385354787129	-89.5805305687638	MONTGOMERY
end	39.1539913389194	-89.561368040102	MONTGOMERY

Cress Creek

41

	start	39.1652709439739	-89.5012992382647	MONTGOMERY
	end	39.1962551507602	-89.5131844155481	MONTGOMERY
Dry Fork				
43				
	start	39.036113738887	-89.2488135289512	FAYETTE
	end	39.1033131262537	-89.2984242244004	MONTGOMERY
East Fork Shoal Creek				
23				
	start	38.8310032253066	-89.4990300331039	BOND
	end	38.9226451880864	-89.4117554251748	BOND
Gerhardt Creek				
27				
	start	38.3445550793694	-90.0600653224456	ST. CLAIR
	end	38.367857922464	-90.0997565611344	MONROE
Hurricane Creek				
42				
	start	38.9180334233238	-89.2472989134191	FAYETTE
	end	39.2167946546678	-89.2767284135051	MONTGOMERY
Loop Creek				
21				
	start	38.4738791704891	-89.8286629587977	ST. CLAIR
	end	38.4996759642082	-89.9058988238884	ST. CLAIR
Middle Fork Shoal Creek				
40				
	start	39.0848984732588	-89.5438724131899	MONTGOMERY
	end	39.1868483992515	-89.4798528829252	MONTGOMERY
Mitchell Creek				
48				
	start	39.1565938305703	-88.9491156388975	FAYETTE
	end	39.3191569074355	-88.9291931738519	SHELBY
Mud Creek				

51				
	start	39.4078984061571	-88.8964126852371	SHELBY
	end	39.4786612118046	-88.9523280946578	SHELBY
Ninemile Creek				
30				
	start	38.0441291788376	-89.9112042263573	RANDOLPH
	end	38.0507383485977	-89.8278402421236	RANDOLPH
Opossum Creek				
46				
	start	39.2718719283603	-89.006345202583	SHELBY
	end	39.2833737967471	-89.0555186821259	SHELBY
Prairie du Long Creek				
24				
	start	38.2583950460692	-89.9674114204896	MONROE
	end	38.3425597902873	-90.0517323138269	ST. CLAIR
Robinson Creek				
50				
	start	39.3519556417502	-88.8434641389225	SHELBY
	end	39.5215530679793	-88.8331635597113	SHELBY
Rockhouse Creek				
25				
	start	38.279441694169	-90.0367398173562	MONROE
	end	38.2999005789932	-90.1039357731424	MONROE
Section Creek				
49				
	start	39.1835497280833	-88.9455894742885	FAYETTE
	end	39.1959160048126	-88.961892707007	FAYETTE
Shoal Creek				
22				
	start	38.4831106563982	-89.5775456200079	WASHINGTON
	end	38.5557239981111	-89.4968640710432	CLINTON

36				
	start	38.8310032008922	-89.4990300493802	BOND
	end	39.0848755752581	-89.5439018081354	MONTGOMERY
Silver Creek				
20				
	start	38.3369025707936	-89.8753691916515	ST. CLAIR
	end	38.5568068204478	-89.8305698867169	ST. CLAIR
Stringtown Branch				
53				
	start	39.7138824796477	-88.6677549810426	MOULTRIE
	end	39.7363136714592	-88.6944718913546	MOULTRIE
Unnamed Tributary of Gerhardt Creek				
26				
	start	38.367857922464	-90.0997565611344	MONROE
	end	38.3742880966457	-90.1107074126403	MONROE
Unnamed Tributary of Okaw River				
54				
	start	39.734248747064	-88.6620801587617	MOULTRIE
	end	39.80990395294	-88.6969360645412	PIATT
Walters Creek				
28				
	start	38.3425597902873	-90.0517323138269	ST. CLAIR
	end	38.3445550793694	-90.0600653224456	ST. CLAIR
West Fork Shoal Creek				
38				
	start	39.1385354787129	-89.5805305687638	MONTGOMERY
	end	39.1877434015581	-89.6041666305308	MONTGOMERY
West Okaw River				
52				
	start	39.6158126349278	-88.7105522558061	MOULTRIE

end	39.7564321977535	-88.630211952428	MOULTRIE

Mississippi River

Apple River

372

start	42.3210892387922	-90.2520915343109	JO DAVIESS
end	42.5078007598632	-90.1320538371008	JO DAVIESS

Bear Creek

199

start	40.1421908412793	-91.322057103417	ADAMS
end	40.3507607406412	-91.1831593883194	HANCOCK

Bigneck Creek

205

start	40.1189668648562	-91.2247381726013	ADAMS
end	40.118891177483	-91.1409739765636	ADAMS

Burton Creek

192

start	39.8643091712617	-91.343323220756	ADAMS
end	39.92393403238	-91.2381482737218	ADAMS

Camp Creek

140

start	41.2607621817314	-90.514303172809	MERCER
end	41.3114464274682	-90.2476056448033	HENRY

142

start	41.2202380211465	-90.895164796358	MERCER
end	41.2787933006746	-90.6950345992843	MERCER

Carroll Creek

349

start	42.1027782814517	-90.0265311556732	CARROLL
end	42.0906369943302	-89.8985337135691	CARROLL

Clear Creek

6				
	start	37.4821139304798	-89.377768200259	UNION
	end	37.5377402977406	-89.331689550578	UNION
381				
	start	42.4468385101031	-90.0472460146999	JO DAVIESS
	end	42.4780763391708	-90.035127804618	JO DAVIESS
Coon Creek				
376				
	start	42.4035528739642	-90.1272819897867	JO DAVIESS
	end	42.4347098804951	-90.1169407822902	JO DAVIESS
Copperas Creek				
148				
	start	41.3717279574558	-90.901871458269	ROCK ISLAND
	end	41.3616090539824	-90.7468725613692	ROCK ISLAND
Deep Run				
155				
	start	40.7779166934519	-90.9639489255706	HENDERSON
	end	40.794076798068	-90.9474772904134	HENDERSON
Dixson Creek				
154				
	start	40.7684181600505	-90.9376123103323	HENDERSON
	end	40.7650613473293	-90.9262679175808	HENDERSON
Dutch Creek				
4				
	start	37.4593003249666	-89.3688365937935	UNION
	end	37.4147572383786	-89.2744790735331	UNION
East Fork Galena River				
383				
	start	42.450241615252	-90.3876497193745	JO DAVIESS
	end	42.4876693698893	-90.286894403861	JO DAVIESS
Edwards River				

145				
	start	41.1459068953479	-90.9832855425151	MERCER
	end	41.2835429634312	-90.1022166001482	HENRY
Eliza Creek				
146				
	start	41.2754465656779	-90.9740195834639	MERCER
	end	41.2948140261561	-90.8870757880317	MERCER
Ellison Creek				
153				
	start	40.7615810139869	-91.0723400800456	HENDERSON
	end	40.7295594797542	-90.7480413061409	WARREN
Galena River				
382				
	start	42.450241615252	-90.3876497193745	JO DAVIESS
	end	42.5068721036534	-90.390459616835	JO DAVIESS
Green Creek				
5				
	start	37.4514943718452	-89.3379244013686	UNION
	end	37.4666314694209	-89.3048476846202	UNION
Hadley Creek				
188				
	start	39.7025380326419	-91.1396851101986	PIKE
	end	39.7351716794518	-90.9664567571417	PIKE
Hells Branch				
378				
	start	42.3582317355027	-90.185076448587	JO DAVIESS
	end	42.4166702490621	-90.1660286242329	JO DAVIESS
Henderson Creek				
134				
	start	41.0518601460692	-90.652709618504	WARREN
	end	41.0728998007979	-90.3331881878676	KNOX

150				
	start	40.8788582366336	-90.9641994146698	HENDERSON
	end	40.989888583038	-90.8698875032336	HENDERSON
Hillery Creek				
144				
	start	41.2699394405307	-90.2020116075301	HENRY
	end	41.2553101029329	-90.1954503442612	HENRY
Honey Creek				
157				
	start	40.7000823335975	-91.0347691132118	HENDERSON
	end	40.7064734203141	-90.8589436695132	HENDERSON
186				
	start	39.4871465283426	-90.7799240715991	PIKE
	end	39.5633421986505	-90.8011460205638	PIKE
207				
	start	40.1052246871151	-91.2149469620062	ADAMS
	end	40.0689996865178	-91.2253825583113	ADAMS
Hutchins Creek				
7				
	start	37.5043385818368	-89.3755380391598	UNION
	end	37.58788138261	-89.3917584202331	UNION
Little Bear Creek				
194				
	start	40.3213003292038	-91.2390256840921	HANCOCK
	end	40.302753021887	-91.3102530307924	HANCOCK
Little Creek				
200				
	start	40.1807360433073	-91.2803860136891	ADAMS
	end	40.230127123031	-91.3051461065984	HANCOCK
McCraney Creek				
189				

	start	39.7167396162723	-91.1729844320811	PIKE
	end	39.8572624790589	-91.0907175471865	ADAMS
Mill Creek				
191				
	start	39.8643091712617	-91.343323220756	ADAMS
	end	39.9675786362521	-91.2477003180771	ADAMS
377				
	start	42.3539782358808	-90.1879698650198	JO DAVIESS
	end	42.4518923573772	-90.2485882677025	JO DAVIESS
496				
	start	38.9472270910927	-90.2956721236088	JERSEY
	end	38.9871246152411	-90.3431576290565	JERSEY
Mississippi River				
2				
	end	37.1887629940337	-89.4576720472899	ALEXANDER
29				
	start	38.8664117755941	-90.1477786925267	MADISON
	end	38.327795025976	-90.3709302644266	MONROE
384				
	start	42.5079432477656	-90.6430378486115	JO DAVIESS
	end	41.5746193723759	-90.392321397091	ROCK ISLAND
440				
	start	39.326689248302	-90.8243988873681	CALHOUN
	end	39.8935238218567	-91.4437639810547	ADAMS
Mud Creek				
202				
	start	40.1812148450863	-91.2785060826782	ADAMS
	end	40.1852755387137	-91.2660018265735	ADAMS
Nichols Run				
156				
	start	40.7735451176215	-90.9672827833242	HENDERSON

	end	40.7648298879037	-90.9675416302885	HENDERSON
North Henderson Creek				
136				
	start	41.0973619647032	-90.7191141378965	MERCER
	end	41.119743833988	-90.4494190524502	MERCER
Parker Run				
141				
	start	41.2623500459087	-90.4891341819923	MERCER
	end	41.2260011828886	-90.4145431241447	HENRY
Pigeon Creek				
190				
	start	39.7143204171354	-91.2372670411405	PIKE
	end	39.8220301600964	-91.2087922935523	ADAMS
Pope Creek				
137				
	start	41.1401437091914	-90.8116816399802	MERCER
	end	41.1394137238591	-90.2877112230995	KNOX
Sixmile Creek				
187				
	start	39.4592604039597	-90.8902507134236	PIKE
	end	39.5431657559583	-90.8891598316201	PIKE
Slater Creek				
198				
	start	40.291601584329	-91.2423526162923	HANCOCK
	end	40.2822885732908	-91.2189777154329	HANCOCK
Smith Creek				
152				
	start	40.9297989285848	-90.9146232873076	HENDERSON
	end	40.9291958384872	-90.7919464822621	HENDERSON
South Edwards River				
139				

	start	41.2656645104853	-90.2611866223557	HENRY
	end	41.1927071399434	-90.0393078982573	HENRY
South Fork Apple River				
380				
	start	42.4468385101031	-90.0472460146999	JO DAVIESS
	end	42.4176188464167	-89.9845802036023	JO DAVIESS
South Fork Bear Creek				
203				
	start	40.1677973436879	-91.2933473698779	ADAMS
	end	40.0950329934447	-91.0607522810856	ADAMS
South Henderson Creek				
135				
	start	41.0188478643653	-90.4811337762604	WARREN
	end	41.0121123609019	-90.4338464913801	KNOX
151				
	start	40.8788582366336	-90.9641994146698	HENDERSON
	end	40.8534764362853	-90.8707263659685	HENDERSON
Straddle Creek				
301				
	start	42.0906369943302	-89.8985337135691	CARROLL
	end	42.1316680929413	-89.783599495409	CARROLL
Thurman Creek				
204				
	start	40.1277667094818	-91.234525810555	ADAMS
	end	40.1580795200863	-91.1501036788115	ADAMS
Tournear Creek				
193				
	start	39.9042285951329	-91.2447718289928	ADAMS
	end	39.8738503674823	-91.1658282439773	ADAMS
Unnamed Tributary of Apple River				
375				

	start	42.3613497834653	-90.1603277978963	JO DAVIESS
	end	42.3651703478401	-90.1182227692179	JO DAVIESS
Unnamed Tributary of Bear Creek				
197				
	start	40.3187160045841	-91.2379753573306	HANCOCK
	end	40.3220475782343	-91.2218711128768	HANCOCK
201				
	start	40.2483484763178	-91.2634157983708	HANCOCK
	end	40.2576281291385	-91.2420554576986	HANCOCK
Unnamed Tributary of Copperas Creek				
149				
	start	41.3759130587612	-90.8569366994939	ROCK ISLAND
	end	41.3735944469795	-90.829794872711	ROCK ISLAND
Unnamed Tributary of Furnace Creek				
373				
	start	42.3419228115146	-90.2583358633166	JO DAVIESS
	end	42.3737126096251	-90.2971522307335	JO DAVIESS
374				
	start	42.3419228115146	-90.2583358633166	JO DAVIESS
	end	42.3615209718591	-90.24931703774	JO DAVIESS
Unnamed Tributary of South Edwards River				
143				
	start	41.2011516193172	-90.1850818577344	HENRY
	end	41.1943841818099	-90.1839265246101	HENRY
Unnamed Tributary of South Fork of Bear Creek				
206				
	start	40.0797919556019	-91.1461193615862	ADAMS
	end	40.0587441356106	-91.1467388825794	ADAMS
West Fork Apple River				

379

start	42.4777531846594	-90.1103501186504	JO DAVIESS
end	42.4739843218597	-90.1321517307332	JO DAVIESS

West Fork of Bear Creek

195

start	40.3385207135212	-91.2203393068898	HANCOCK
end	40.3592824400704	-91.2334357995319	HANCOCK

Yankee Branch

147

start	41.2850778212191	-90.9379823025264	MERCER
end	41.2926277702981	-90.9335620769218	MERCER

Ohio

Big Creek

16

start	37.4366764302436	-88.3127424957005	HARDIN
end	37.5591274535694	-88.3148730216063	HARDIN

Big Grand Pierre Creek

13

start	37.4163002207384	-88.4338876873615	POPE
end	37.5702304746463	-88.4292613661871	POPE

Hayes Creek

10

start	37.4452331751972	-88.7114120959417	JOHNSON
end	37.4559134065693	-88.6286228702431	POPE

Hicks Branch

14

start	37.5432903813926	-88.4245265989312	POPE
end	37.5391971894773	-88.4135144509885	HARDIN

Little Lusk Creek

12

	start	37.4991426291527	-88.5277357332102	POPE
	end	37.5247950767618	-88.5017934865946	POPE
Little Saline River				
9				
	start	37.6429893859023	-88.6229273282692	SALINE
	end	37.5783125058777	-88.7169929932876	JOHNSON
Lusk Creek				
11				
	start	37.3685952948804	-88.4926140087969	POPE
	end	37.5649232438096	-88.5644984122843	POPE
Mississippi River				
2				
	start	36.9810279805712	-89.1311552055554	ALEXANDER
Ohio River				
1				
	start	36.9810279805712	-89.1311552055554	ALEXANDER
	end	37.7995447392016	-88.0255709974801	GALLATIN
Simmons Creek				
15				
	start	37.4274681380208	-88.4392381154217	POPE
	end	37.4644921054999	-88.4850750109356	POPE
South Fork Saline River				
8				
	start	37.6372646144582	-88.6447143188352	SALINE
	end	37.6650992000287	-88.7471054185807	WILLIAMSON
Unnamed Tributary of Big Creek				
18				
	start	37.4816237108967	-88.3412279259479	HARDIN
	end	37.4836843600581	-88.3434390004066	HARDIN
Wabash River				
488				

start	37.7995447392016	-88.0255709974801	GALLATIN

Rock

Beach Creek

302

start	41.8989215290323	-89.121081932608	OGLE
end	41.8637759544565	-89.185844184387	LEE

Beaver Creek

322

start	42.2551087433884	-88.9247700103803	BOONE
end	42.4341346635117	-88.7603784300954	BOONE

Black Walnut Creek

341

start	42.1132080942552	-89.2141520188153	OGLE
end	42.061557908797	-89.2316600156935	OGLE

Brown Creek

335

start	42.3568412672282	-89.4493817584574	STEPHENSON
end	42.3697340053709	-89.4802304815634	STEPHENSON

Buffalo Creek

358

start	41.9242552302868	-89.6809355972221	WHITESIDE
end	41.9752373833258	-89.6243677263482	OGLE

Cedar Creek

337

start	42.3709196286357	-89.670256711355	STEPHENSON
end	42.3896058186609	-89.5870343171161	STEPHENSON

Coal Creek

208

start	41.3941767873198	-89.8287586795479	BUREAU
end	41.2930847238959	-89.6659810678663	BUREAU

Coon Creek

304

start	42.0365871032824	-89.489365571257	OGLE
end	42.0550520228278	-89.4762995939105	OGLE

326

start	42.254519734978	-88.7945563884938	BOONE
end	42.1336677087989	-88.6039205825106	DE KALB

Crane Grove Creek

371

start	42.2656461748962	-89.6058461735176	STEPHENSON
end	42.2317224844045	-89.5804359629382	STEPHENSON

Deer Creek

307

start	42.1046195671697	-88.7267155451459	DE KALB
end	42.1076541965304	-88.6684575625598	DE KALB

Dry Creek

332

start	42.4322162336943	-89.0509181181504	WINNEBAGO
end	42.4892211712754	-88.9789486331688	WINNEBAGO

East Branch South Branch of Kishwaukee River

306

start	42.0108038948242	-88.7236807475971	DE KALB
end	41.9822037358546	-88.5449399063616	KANE

East Fork Mill Creek

343

start	42.1402053009442	-89.2945061380348	OGLE
end	42.1744627607887	-89.268245093523	OGLE

Elkhorn Creek

350

start	41.8392614813286	-89.6956810578758	WHITESIDE
end	42.0864514128748	-89.636841111792	OGLE

Franklin Creek

303

start	41.8885909580789	-89.4120344682789	OGLE
end	41.830393186845	-89.3092915487959	LEE

Goose Creek

356

start	41.9282951879448	-89.692114617634	WHITESIDE
end	41.9476422569681	-89.6849104470831	OGLE

Green River

359

start	41.6266589513433	-89.5688644755145	LEE
end	41.8177589430141	-89.1263088319088	LEE

Kilbuck Creek

312

start	42.1838622639314	-89.1301689015062	WINNEBAGO
end	41.9181917577798	-88.9212387567239	DE KALB

Kingsbury Creek

311

start	42.1077794424363	-88.8726630666396	DE KALB
end	42.1579325310556	-88.8548684690422	BOONE

Kishwaukee River

318

start	42.1866384939252	-89.1320796977525	WINNEBAGO
end	42.2666635150817	-88.5250450377336	MCHENRY

Kyte River

295

start	41.9881250432719	-89.3232327202272	OGLE
end	41.9206998470585	-89.0576692414087	OGLE

Leaf River

345

start	42.093677393629	-89.3249228482157	OGLE

	end	42.1545774626081	-89.5725820219443	OGLE
Lost Creek				
368				
	start	42.245723132043	-89.7807765552299	STEPHENSON
	end	42.2314500223394	-89.7709518073782	STEPHENSON
Middle Creek				
344				
	start	42.1559584011258	-89.2911997709031	OGLE
	end	42.1737499306461	-89.2931763612625	OGLE
Mill Creek				
342				
	start	42.1206847838382	-89.2792143996076	OGLE
	end	42.2092574596508	-89.3358557551327	WINNEBAGO
Mosquito Creek				
323				
	start	42.3066628798583	-88.9047855300292	BOONE
	end	42.3100003482313	-88.9099328193755	BOONE
327				
	start	42.246521748985	-88.7802719043895	BOONE
	end	42.1906300595167	-88.7849304281662	BOONE
Mud Creek				
325				
	start	42.2592878387497	-88.7503449689069	BOONE
	end	42.2805097009077	-88.7381130663589	BOONE
346				
	start	42.1301628959448	-89.4043328758949	OGLE
	end	42.1639762007661	-89.4554911246235	OGLE
North Branch Kishwaukee River				
320				
	start	42.2655855837644	-88.5514660318739	MCHENRY
	end	42.4163330454161	-88.5232715616737	MCHENRY

North Branch Otter Creek

292

start	42.4412940471901	-89.3074016078782	WINNEBAGO
end	42.4570625094589	-89.356265092275	WINNEBAGO

North Fork Kent Creek

333

start	42.2621663352674	-89.0944316410734	WINNEBAGO
end	42.310438304708	-89.1651357273603	WINNEBAGO

Otter Creek

291

start	42.4565457866811	-89.2410171137247	WINNEBAGO
end	42.4412940471901	-89.3074016078782	WINNEBAGO

348

start	42.1345277930786	-89.411492883497	OGLE
end	42.1911608097275	-89.4222625773931	OGLE

Owens Creek

310

start	42.1012605056104	-88.8850996053184	DE KALB
end	41.994362186304	-88.8506687869106	DE KALB

Pine Creek

305

start	41.9113031895505	-89.452879176459	OGLE
end	42.0376146514025	-89.4909007464322	OGLE

Piscasaw Creek

324

start	42.2618063936707	-88.8176068924198	BOONE
end	42.3916885547221	-88.7041339551642	MCHENRY

Raccoon Creek

328

start	42.4479288873423	-89.098286193015	WINNEBAGO
end	42.4829761640917	-89.1400856130022	WINNEBAGO

Reid Creek

353

start	41.8644109921615	-89.5919014348703	LEE
end	41.9135187969506	-89.5728723309406	OGLE

Richland Creek

336

start	42.3456275295301	-89.6832413426115	STEPHENSON
end	42.5047442687577	-89.6477619118761	STEPHENSON

Rock River

294

start	41.9881250432719	-89.3232327202272	OGLE
end	42.4962174640048	-89.0418910839077	WINNEBAGO

Rock Run

490

start	42.3211872463585	-89.4237342452712	STEPHENSON
end	42.4281098959774	-89.4483616268915	STEPHENSON

Rush Creek

321

start	42.2560676137827	-88.7031592940742	MCHENRY
end	42.4031741332744	-88.5930626223964	MCHENRY

Silver Creek

338

start	42.0611717976691	-89.335901928201	OGLE
end	42.0866765435436	-89.3839889015445	OGLE

Skunk Creek

354

start	41.8794703976699	-89.7072621672884	WHITESIDE
end	41.897582187238	-89.7290746844729	WHITESIDE

South Branch Kishwaukee River

308

start	42.2001609257306	-88.9840657029051	WINNEBAGO

	end	41.9015798699947	-88.7706697182685	DE KALB
315				
	start	42.2627093767756	-88.5609522875415	MCHENRY
	end	42.1066209842679	-88.4620443477841	KANE
South Branch of Otter Creek				
280				
	start	42.4412940471901	-89.3074016078782	WINNEBAGO
	end	42.4343122756071	-89.3600650183381	WINNEBAGO
South Fork of Leaf River				
347				
	start	42.1296104494647	-89.4546456401589	OGLE
	end	42.1085718337046	-89.5037134270228	OGLE
South Kinnikinnick Creek				
330				
	start	42.419961259532	-89.018119476068	WINNEBAGO
	end	42.4190921988888	-88.8710507717794	BOONE
Spring Creek				
339				
	start	42.0709215390383	-89.325546679708	OGLE
	end	42.0590157098796	-89.3110803788049	OGLE
Spring Run				
313				
	start	42.0402370001041	-89.0065478421579	OGLE
	end	42.0507770466662	-88.9858854279893	OGLE
Steward Creek				
297				
	start	41.8903673258897	-89.1021064698423	OGLE
	end	41.8259979751563	-88.9624738458404	LEE
Stillman Creek				
340				
	start	42.1259475370515	-89.2319193482332	OGLE

	end	42.0372051268587	-89.1542573242497	OGLE
Sugar Creek				
352				
	start	41.8392614813286	-89.6956810578758	WHITESIDE
	end	41.8644109921615	-89.5919014348703	LEE
Sugar River				
293				
	start	42.4357992567436	-89.1971727593158	WINNEBAGO
	end	42.4982890047043	-89.2624235677856	WINNEBAGO
Sumner Creek				
334				
	start	42.3227762010459	-89.3830042631004	WINNEBAGO
	end	42.25195988987	-89.3997975146614	STEPHENSON
Turtle Creek				
329				
	start	42.4929910323531	-89.0439958173493	WINNEBAGO
	end	42.4961371053418	-89.0246519221989	WINNEBAGO
Unnamed Tributary				
361				
	start	41.6608316904842	-89.4728200038511	LEE
	end	41.6425311558513	-89.4137140926471	LEE
365				
	start	41.7443681625006	-89.168951821186	LEE
	end	41.738182745458	-89.1042187039322	LEE
492				
	start	42.1246069284208	-88.5882544654343	DE KALB
	end	42.1028295788327	-88.5105326912596	KANE
Unnamed Tributary of Buffalo Creek				
357				
	start	41.9332348110612	-89.6342816030603	OGLE
	end	41.93890647032	-89.6092042883405	OGLE

Unnamed Tributary of Coon Creek				
282				
	start	42.1336677087989	-88.6039205825106	DE KALB
	end	42.0754334787177	-88.5442273447775	KANE
491				
	start	42.150113155436	-88.6091713292612	DE KALB
	end	42.1691790844289	-88.5070973943593	MCHENRY
Unnamed Tributary of Elkhorn Creek				
355				
	start	41.9378871254405	-89.7318712136894	CARROLL
	end	41.9525180771018	-89.7332762139612	CARROLL
Unnamed Tributary of Green River				
360				
	start	41.8177589430141	-89.1263088319088	LEE
	end	41.8012094828667	-89.0296681468724	LEE
362				
	start	41.66455888603	-89.4729486542104	LEE
	end	41.650155479351	-89.4398464027055	LEE
364				
	start	41.750735979575	-89.2189268880904	LEE
	end	41.7278383993539	-89.1577958588247	LEE
366				
	start	41.7304138832457	-89.2547363744761	LEE
	end	41.7421804770435	-89.2683034846455	LEE
367				
	start	41.7336722733557	-89.2459381167869	LEE
	end	41.6996843512729	-89.2025409068097	LEE
489				
	start	41.7765356433433	-89.1781811586274	LEE
	end	41.791148742648	-89.1782543204659	LEE

Unnamed Tributary of Kyte River

298

start	41.969037423435	-89.2727932207785	OGLE
end	41.9423468128644	-89.2676252361535	OGLE

299

start	41.9474122868214	-89.1742920304606	OGLE
end	41.9511979792854	-89.1378721025283	OGLE

Unnamed Tributary of North Branch Kishwaukee River

319

start	42.4163330454161	-88.5232715616737	MCHENRY
end	42.4218523642031	-88.5063783493938	MCHENRY

Unnamed Tributary of Rock River

331

start	42.3730089457359	-89.0581319432428	WINNEBAGO
end	42.382841503485	-89.0950184603254	WINNEBAGO

Unnamed Tributary of South Branch Kishwaukee River

309

start	42.1219922946716	-88.9236557341498	DE KALB
end	42.1138208388943	-88.9372243118963	DE KALB

316

start	42.1565644453666	-88.4449935784875	MCHENRY
end	42.1594149792506	-88.4178533576301	MCHENRY

317

start	42.234010247227	-88.5199093723576	MCHENRY
end	42.2225793216803	-88.5259266256801	MCHENRY

Unnamed Tributary of Spring Run

314

start	42.0401565844742	-88.9948863767949	OGLE

	end	42.0116835703089	-88.9710672286801	OGLE
Unnamed Tributary of Steward Creek				
296				
	start	41.8444592840822	-89.0070046248547	LEE
	end	41.8601589546913	-88.9714244440014	LEE
300				
	start	41.871719116543	-89.069434926448	LEE
	end	41.8792477545579	-89.037635229652	LEE
Unnamed Tributary of Yellow Creek				
369				
	start	42.3067615221991	-89.8535571166391	STEPHENSON
	end	42.3493669268537	-89.8275355259147	STEPHENSON
West Fork Elkhorn Creek				
351				
	start	42.0864514128748	-89.636841111792	OGLE
	end	42.0924853439498	-89.6474944357754	OGLE
Willow Creek				
363				
	start	41.7653209616214	-89.1943294683724	LEE
	end	41.7141851660088	-89.032161004274	LEE
Yellow Creek				
370				
	start	42.2899156684427	-89.5696276563017	STEPHENSON
	end	42.3796215769162	-89.9350879560031	JO DAVIESS

Wabash

Bean Creek				
437				
	start	40.2950579779894	-87.7823902126108	VERMILION
	end	40.3344744135429	-87.7494458762005	VERMILION

Big Creek

457

start	39.3351439545995	-87.5878012286214	CLARK
start	39.436126036547	-87.7023848396263	CLARK

Bluegrass Creek

436

start	40.301292752824	-87.7969361668719	VERMILION
end	40.381268589802	-87.8562389558508	VERMILION

Brouilletts Creek

450

start	39.7057649552945	-87.5509615193818	EDGAR
end	39.797449971524	-87.7178559181463	EDGAR

Brush Creek

468

start	38.993072718826	-88.1273817532169	JASPER
end	38.9675510537677	-88.1471375817992	JASPER

Brushy Fork

484

start	39.7161188745587	-88.0853294840712	DOUGLAS
end	39.8111289403664	-87.8839288887749	EDGAR

Buck Creek

435

start	40.3115126234324	-87.9255710854089	VERMILION
end	40.2862675329103	-87.9704593374522	CHAMPAIGN

Cassell Creek

473

start	39.4866434423672	-88.2094970436354	COLES
end	39.4909698054293	-88.207848854172	COLES

Catfish Creek

477

start	39.680891264864	-87.9341744320393	EDGAR

	end	39.6581354970801	-87.8937116601235	EDGAR
Clark Branch				
483				
	start	39.8111289403664	-87.8839288887749	EDGAR
	end	39.8226610039489	-87.8513747624001	EDGAR
Collison Branch				
439				
	start	40.2351860050982	-87.7725365689525	VERMILION
	end	40.2197161120333	-87.803155121171	VERMILION
Cottonwood Creek				
469				
	start	39.2033657707304	-88.2765033266093	CUMBERLAND
	end	39.3142137713574	-88.229342077034	CUMBERLAND
Crabapple Creek				
452				
	start	39.7057649552945	-87.5509615193818	EDGAR
	end	39.8065708276187	-87.6467768455628	EDGAR
Crooked Creek				
465				
	start	38.9817031629594	-88.066438923761	JASPER
	end	39.0356467346919	-88.0923368283887	JASPER
Deer Creek				
485				
	start	39.7053403128076	-88.0850387247647	DOUGLAS
	end	39.7025679945443	-88.2058470030399	DOUGLAS
Donica Creek				
479				
	start	39.6453315324326	-87.9892294370803	COLES
	end	39.6172623271272	-87.9782640861296	COLES
Dudley Branch				
475				

	start	39.5115642227627	-88.0564563693231	COLES
	end	39.5068188298145	-88.043669581567	COLES
East Crooked Creek				
287				
	start	39.0356467346919	-88.0923368283887	JASPER
	end	39.1659729856615	-88.0610310241876	JASPER
East Fork Big Creek				
458				
	start	39.436126036547	-87.7023848396263	CLARK
	end	39.5471103780713	-87.760040304497	EDGAR
Embarras River				
460				
	start	38.9148628762488	-87.9834798036322	JASPER
	end	39.7161188745587	-88.0853294840712	DOUGLAS
Feather Creek				
432				
	start	40.1172818042134	-87.8342855159987	VERMILION
	end	40.1416543211304	-87.8399367268356	VERMILION
Greasy Creek				
480				
	start	39.6325904592965	-88.0822649850404	COLES
	end	39.6182255297223	-88.1320998047424	COLES
Hickory Creek				
464				
	start	38.9714278418083	-87.972721454297	JASPER
	end	38.99191464315	-87.989292523907	JASPER
Hickory Grove Creek				
478				
	start	39.6581354970801	-87.8937116601235	EDGAR
	end	39.5712873627184	-87.8825676201308	EDGAR
Hurricane Creek				

470				
	start	39.2889007816578	-88.1544749600653	CUMBERLAND
	end	39.3793118297358	-88.0668208708762	COLES
Jordan Creek				
433				
	start	40.0794151192358	-87.7990673709556	VERMILION
	end	40.0588834821927	-87.8360461636444	VERMILION
443				
	start	40.3360527696651	-87.6231745570584	VERMILION
	end	40.3553265493525	-87.5278198412106	VERMILION
Kickapoo Creek				
471				
	start	39.4379695819539	-88.1681483569976	COLES
	end	39.4597583113682	-88.2917593820249	COLES
Knights Branch				
438				
	start	40.2763499940372	-87.7961879249888	VERMILION
	end	40.2520446574291	-87.8336356533235	VERMILION
Little Embarras River				
476				
	start	39.5736361588448	-88.0726889440362	COLES
	end	39.680891264864	-87.9341744320393	EDGAR
Little Vermilion River				
426				
	start	39.9463345271443	-87.5536756201362	VERMILION
	end	39.9593741043792	-87.6447473681732	VERMILION
Middle Branch				
442				
	start	40.3096675860339	-87.6376716065503	VERMILION
	end	40.417753327133	-87.5275419211693	VERMILION
Middle Fork Vermilion River				

428				
	start	40.1035656386662	-87.7169902321166	VERMILION
	end	40.4043343147541	-88.0191381621282	FORD
Mill Creek				
487				
	start	39.2394256838229	-87.6762126527038	CLARK
	end	39.3566749194214	-87.7425049309309	CLARK
Muddy Creek				
242				
	start	39.1821395682335	-88.2309155529877	CUMBERLAND
	end	39.2033657707304	-88.2765033266093	CUMBERLAND
North Fork of Embarras River				
461				
	start	38.9148628762488	-87.9834798036322	JASPER
	end	39.0924749553725	-87.9784039128617	JASPER
North Fork Vermilion River				
441				
	start	40.236054881277	-87.6293326109766	VERMILION
	end	40.5010729612407	-87.5261721834388	IROQUOIS
Panther Creek				
462				
	start	39.0924749553725	-87.9784039128617	JASPER
	end	39.184289386946	-88.0087906828419	CUMBERLAND
Polecat Creek				
474				
	start	39.5013303165832	-88.1055006912296	COLES
	end	39.5162859310237	-88.0338496162262	COLES
Riley Creek				
472				
	start	39.4712869216685	-88.2108945161318	COLES
	end	39.5116227820733	-88.2569469311765	COLES

Salt Fork				
429				
	start	40.1035656386662	-87.7169902321166	VERMILION
	end	40.0368232483006	-88.0746580039075	CHAMPAIGN
455				
	start	39.7425080214619	-87.572919448772	EDGAR
	end	39.8018493662144	-87.5775868051385	EDGAR
Snake Creek				
454				
	start	39.7128111863363	-87.6415954465778	EDGAR
	end	39.7066978623237	-87.6543043306751	EDGAR
South Fork Brouilletts Creek				
453				
	start	39.7256495590209	-87.6437626049444	EDGAR
	end	39.7319449005729	-87.6951881181821	EDGAR
Stony Creek				
431				
	start	40.0943454186494	-87.8170769835194	VERMILION
	end	40.1548847864725	-87.8840063394108	VERMILION
Sugar Creek				
456				
	start	39.4838820536199	-87.5320762217325	EDGAR
	end	39.6298164781408	-87.6762882912482	EDGAR
Unnamed Tributary of Big Creek				
459				
	start	39.5047911835054	-87.7121475341945	EDGAR
	end	39.5692784693864	-87.7194139533441	EDGAR
Unnamed Tributary of Brouilletts Creek				
451				
	start	39.797449971524	-87.7178559181463	EDGAR

	end	39.831592697221	-87.7758036967074	EDGAR
Unnamed Tributary of Brushy Fork				
482				
	start	39.7340344129883	-88.0771406153965	DOUGLAS
	end	39.802586616189	-88.0753634663247	DOUGLAS
Unnamed Tributary of Deer Creek				
486				
	start	39.7102184848625	-88.1385435180688	DOUGLAS
	end	39.678866903649	-88.1425332064637	DOUGLAS
Unnamed Tributary of Embarras River				
467				
	start	38.9934159067144	-88.129258689394	JASPER
	end	39.0034725453128	-88.1210073578163	JASPER
Unnamed Tributary of Greasy Creek				
481				
	start	39.6182255297223	-88.1320998047424	COLES
	end	39.621059195964	-88.1538483534688	COLES
Unnamed Tributary of Hickory Creek				
210				
	start	38.99191464315	-87.989292523907	JASPER
	end	39.0117394234421	-87.9896104862878	JASPER
Unnamed Tributary of Middle Fork Vermilion River				
434				
	start	40.3478602982847	-87.9479087836067	CHAMPAIGN
	end	40.3408935605508	-87.9885982351498	CHAMPAIGN
Unnamed Tributary of Stony Creek				
430				
	start	40.1548847864725	-87.8840063394108	VERMILION

	end	40.1706704853124	-87.9033972187304	VERMILION
Unnamed Tributary of North Fork of the Vermilion River				
444				
	start	40.3553498759616	-87.6852979017427	VERMILION
	end	40.3665727663496	-87.733231992072	VERMILION
445				
	start	40.483638183168	-87.5751075709757	VERMILION
	end	40.4930209841439	-87.5771391859822	IROQUOIS
446				
	start	40.423223711311	-87.6788932053507	VERMILION
	end	40.4280461995299	-87.6895565256772	VERMILION
Vermilion River				
427				
	start	40.0116868805566	-87.5337540394346	VERMILION
	end	40.1035656386662	-87.7169902321166	VERMILION
Wabash River				
488				
	end	39.3034266238732	-87.605592332246	CLARK
West Crooked Creek				
466				
	start	39.0356467346919	-88.0923368283887	JASPER
	end	39.0545759701349	-88.1009871944535	JASPER
West Fork Big Creek				
19				
	start	39.436126036547	-87.7023848396263	CLARK
	end	39.5012337820195	-87.8003199656505	EDGAR
Willow Creek				
463				
	start	39.0191952007294	-87.9402449982878	CRAWFORD
	end	39.0529145507759	-87.9280073176635	CRAWFORD

POLLUTION CONTROL BOARD

NOTICE OF PROPOSED AMENDMENTS

(Source: Added at 31 Ill. Reg. _____, effective _____)

POLLUTION CONTROL BOARD

NOTICE OF PROPOSED AMENDMENT

1) Heading of the Part: Solid Waste Disposal: General Provisions

2) Code Citation: 35 Ill. Adm. Code 810

3) Section Number: 810.104 Proposed Action: Amend

4) Statutory Authority: Implementing Sections 7.2, 21, 21.1, 22, 22.17, and 22.40 and authorized by Section 27 of the Environmental Protection Act [415 ILCS 5/7.2, 21, 21.1, 22, 22.17, 22.40, and 27]

5) A Complete Description of the Subjects and Issues Involved: For a more detailed discussion of amendments, see the Board's July 12, 2007 opinion and order in docket R07-8. This rulemaking proposes amendments to Parts 810 and 811 that are intended to update the Board's solid waste disposal regulations in order to reflect practical experience gained through the implementation of those rules and the expanded technical and scientific knowledge achieved since the Board first adopted these standards in 1990. This rulemaking is based on a proposal that was filed with the Board on July 27, 2006, by the Illinois Chapter of the National Solid Wastes Management Association (NSWMA).

The amendments to Part 810 seek to update materials incorporated by reference.

6) Published studies or reports, and sources of underlying data, used to compose this rulemaking: None

7) Will this proposed rulemaking replace any emergency rulemaking currently in effect? No

8) Does this rulemaking contain an automatic repeal date? No

9) Does this rulemaking contain incorporations by reference? Yes

10) Are there any other proposed rules pending on this Part? No

11) Statement of Statewide Policy Objectives: This proposed rule does not create or enlarge a State mandate, as defined in Section 3(b) of the State Mandates Act [30 ILCS 805/3(b) (2004)].

12) Time, Place, and Manner in which interested persons may comment on this proposed rulemaking: The Board held hearings on this rulemaking in Chicago on January 29, 2007

and in Springfield on February 28, 2007. The Board will continue to accept written public comment on this proposal for 45 days after the date of publication in the *Illinois Register*. Comments should reference Docket R07-8 and be addressed to:

Clerk's Office
Illinois Pollution Control Board
100 W. Randolph St., Suite 11-500
Chicago, IL 60601

Interested persons may request copies of the Board's opinion and order by calling the Clerk's office at 312-814-3620, or download from the Board's Web site at www.ipcb.state.il.us.

For more information contact Tim Fox at 312/814-6085 or email at foxt@ipcb.state.il.us.

13) Initial Regulatory Flexibility Analysis:

A) Types of small businesses, small municipalities and not for profit corporations affected: This rulemaking will impact any small businesses, small municipalities and not for profit corporations that own or operate a solid waste disposal facility.

B) Reporting, bookkeeping or other procedures required for compliance: This rulemaking does not impose any new reporting, bookkeeping or other procedures.

C) Types of Professional skills necessary for compliance: No professional skills beyond those currently required by the existing state regulations applicable to affected sources will be required.

14) Regulatory Agenda on which this rulemaking was summarized: July 2007

The full text of the Proposed Amendment begins on the next page:

POLLUTION CONTROL BOARD

NOTICE OF PROPOSED AMENDMENT

TITLE 35: ENVIRONMENTAL PROTECTION
SUBTITLE G: WASTE DISPOSAL
CHAPTER I: POLLUTION CONTROL BOARD
SUBCHAPTER i: SOLID WASTE AND SPECIAL WASTE HAULING

PART 810
SOLID WASTE DISPOSAL: GENERAL PROVISIONS

Section
810.101 Scope and Applicability
810.102 Severability
810.103 Definitions
810.104 Incorporations by Reference
810.105 Electronic Reporting

AUTHORITY: Implementing Sections 7.2, 21, 21.1, 22, 22.17, and 22.40 and authorized by Section 27 of the Environmental Protection Act [415 ILCS 5/7.2, 21, 21.1, 22, 22.17, 22.40, and 27].

SOURCE: Adopted in R88-7 at 14 Ill. Reg. 15838, effective September 18, 1990; amended in R93-10 at 18 Ill. Reg. 1268, effective January 13, 1994; amended in R90-26 at 18 Ill. Reg. 12457, effective August 1, 1994; amended in R95-9 at 19 Ill. Reg. 14427, effective September 29, 1995; amended in R96-1 at 20 Ill. Reg. 11985, effective August 15, 1996; amended in R97-20 at 21 Ill. Reg. 15825, effective November 25, 1997; amended in R04-5/R04-15 at 28 Ill. Reg. 9090, effective June 18, 2004; amended in R05-1 at 29 Ill. Reg. 5028, effective March 22, 2005; amended in R06-5/R06-6/R06-7 at 30 Ill. Reg. 4130, effective February 23, 2006; amended in R06-16/R06-17/R06-18 at 31 Ill. Reg. 1425, effective December 20, 2006; amended in R07-8 at 31 Ill. Reg. _____, effective _____.

Section 810.104 Incorporations by Reference

a) The Board incorporates the following material by reference:

1) Code of Federal Regulations:

40 CFR 3.2, as added at 70 Fed. Reg. 59848 (Oct. 13, 2005) (How Does This Part Provide for Electronic Reporting?), referenced in Section 810.105.

40 CFR 3.3, as added at 70 Fed. Reg. 59848 (Oct. 13, 2005) (What Definitions Are Applicable to This Part?), referenced in Section 810.105.

40 CFR 3.10, as added at 70 Fed. Reg. 59848 (Oct. 13, 2005) (What Are the Requirements for Electronic Reporting to EPA?), referenced in Section 810.105.

40 CFR 3.2000, as added at 70 Fed. Reg. 59848 (Oct. 13, 2005) (What Are the Requirements Authorized State, Tribe, and Local Programs' Reporting Systems Must Meet?), referenced in Section 810.105.

40 CFR 141.40 (2005) (Monitoring Requirements for Unregulated Contaminants).

~~Appendix II to 40 CFR 258 (2005), as corrected at 70 Fed. Reg. 44150 (August 1, 2005) (List of Hazardous and Organic Constituents).~~

40 CFR 258.Appendix I (2006).

40 CFR 258.Appendix II (2006).

2) American Institute of Certified Public Accountants, 1211 Avenue of the Americas, New York NY 10036:

Auditing Standards – Current Text, August 1, 1990 Edition.

3) ASTM. American Society for Testing and Materials, 1976 Race Street, Philadelphia PA 19103 215-299-5585:

Method D2234-76, "Test Method for Collection of Gross Samples of Coal," approved 1976.

Method D3987-85, "Standard Test Method for Shake Extraction of Solid Waste with Water," approved 1985.

4) GASB. Government Accounting Standards Board, 401 Merritt 7, P.O.

Box 5116, Norwalk CT 06856-5116:

Statement 18.

5) U.S. Army Corps of Engineers, Publication Department, 2803 52nd Ave., Hyattville, Maryland 20781, 301-394-0081:

Engineering Manual 1110-2-1906 Appendix VII, Falling-Head Permeability Cylinder (1986).

6) U.S. Government Printing Office, Washington, D.C. 20402, Ph: 202-783-3238:

"Test Methods for Evaluating Solid Waste, Physical/Chemical Methods," USEPA publication number EPA-530/SW-846 (Third Edition, 1986; Revision 6, January 2005), as amended by Update I (July 1992), II (September 1994), IIA (August 1993), IIB (January 1995), III (December 1996), IIIA (April 1998), and IIIB (November 2004) (document number 955-001-00000-1).

b) This incorporation includes no later amendments or editions.

(Source: Amended at 31 Ill. Reg. _____, effective _____)

POLLUTION CONTROL BOARD

NOTICE OF PROPOSED AMENDMENTS

1) Heading of the Part: Standards for New Solid Waste Landfills

2) Code Citation: 35 Ill. Adm. Code 811

3)

Section Numbers:	Proposed Action:
811.309	Amend
811.315	Amend
811.318	Amend
811.319	Amend
811.320	Amend
811.APPPENDIX C	New Section

4) Statutory Authority: Implementing Sections 7.2, 21, 21.1, 22, 22.17, and 22.40 and authorized by Section 27 of the Environmental Protection Act [415 ILCS 5/7.2, 21, 21.1, 22, 22.17, 22.40, and 27]

5) A Complete Description of the Subjects and Issues Involved: For a more detailed discussion of these amendments, see the Board's July 12, 2007 opinion and order in docket R07-8. This rulemaking proposes amendments to Part 811 that are intended to update the Board's solid waste disposal regulations to reflect practical experience gained through the implementation of those rules and expanded technical and scientific knowledge achieved since the Board first adopted these standards in 1990. This rulemaking is based on a proposal that was filed with the Board on July 27, 2006, by the Illinois Chapter of the National Solid Wastes Management Association (NSWMA) with the concurrence of the Illinois Environmental Protection Agency (Agency).

NSWMA proposed substantive changes to the Board's nonhazardous solid waste landfill rules. Those proposed changes pertain to issues including leachate monitoring, hydrogeologic site investigation, groundwater monitoring systems, and groundwater quality standards.

The amendments to the leachate monitoring include adding a list of 202 constituents to be monitored. The Agency developed the list to represent constituents likely to be found in leachate from chemical and putrescible waste landfills. The amendments also propose a minimum number of leachate monitoring locations at landfill units. For the first two years of landfill operation, the proposal changes the frequency of leachate monitoring frequency from quarterly to semi-annual monitoring. The proposal does not change the requirement that, after those first two years, monitoring continues on a semi-annual basis. The proposal also requires sampling from each monitoring location at least once every

two years.

At Section 811.315(e)(1)(G)(i), the Board proposes to replace the reference in the rules to 'public or food processing water supply standard at 35 Ill. Adm. Code 302' with a reference to the groundwater standards found at 35 Ill. Adm. Code 620. This amendment replaces the list of constituents under public or food processing water supply standards with a more comprehensive list of constituents under the Board's groundwater standards.

The amendments to the groundwater monitoring systems address the depth of monitoring wells. Specifically, the proposal requires an operator to measure the depth of groundwater monitoring wells that do not contain dedicated pumps on an annual basis. The amendments would also require that, at groundwater monitoring wells containing dedicated pumps, the operator must measure the depth of the well every five years or when the pump is serviced.

Additional amendments to monitoring requirements include adding a specific list of indicator constituents, adding a specific list of organic chemicals for which groundwater must be monitored, and increasing the frequency of the monitoring for the specified organic parameters. The amendments also propose several changes to the provisions for confirming monitored increases.

Proposed changes to the assessment monitoring provisions under Section 811.319(b) include specifying deadlines for submission and implementation of an assessment monitoring plan. Additionally, the proposed inclusion of constituents listed in 35 Ill. Adm. Code 620.410 makes the Board rules consistent with the federal regulations at 40 C.F.R. Part 258.

The amendments propose a number of changes to the groundwater quality standard provisions under Section 811.320. The proposed changes replace references to public water supply standards with references to groundwater standards, clarify the establishment of background concentrations, and update statistical analysis procedures.

6) Published studies or reports, and sources of underlying data, used to compose this rulemaking:

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Cravy, T.D., McIsaac, P., and Gibbons, R.D., 1990, Evaluation of organic indicator parameters using an Appendix VII/IX Database: presented at Wastc Tech '90, Landfill Technology: Back to Basics. San Francisco, CA.

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Heidlauf, D.T. and Bartlett, T.R., 1993, Effects of monitoring well purge and sample techniques on the concentration of metal analytes in unfiltered groundwater samples: Proceedings of the NGWA Outdoor Action Conference, Las Vegas, NV, May 1993, pp. 437-450.

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Plumb, R.H., 1991. The Occurrence of Appendix IX Organic Constituents in Disposal Site Ground Water, Groundwater Monitoring Revicw, Spring 1991, pp. 157-164.

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Puls. R.W., and Powell. R.M.. 1992. Acquisition of Representative Groundwater Quality Samples for Metals, Groundwater Monitoring Review, Summer 92, pp. 167-176.

Allen, H.E., Perdue, E.M., and Brown, D., 1993. Metals in Groundwater. Boca Raton, Florida: Lewis Publishers.

Baker, J.A. "Leachate Characteristics of Leachate Recirculation and Bioreactor Landfills," Presentation at USEPA's 2nd Annual Bioreactor Workshop, Feb. 2003.

Bagchi, A., 1987. Natural attenuation mechanisms of landfill leachate and effects of various factors on the mechanisms. Waste Management & Research 5, 453-464.

Barlaz, M.A., et al, "A Critical Evaluation of Factors Required to Terminate Post-Closure Monitoring and Performance of Solid Waste Landfills," Environmental Science and Technology, 2002, 36, 3457.

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Davis, J.A., et al. 1993. Influence of Redox Environment and Aqueous Speciation on Metal Transport in Groundwater: Preliminary Results of Trace Injection Studies, Metals in Groundwater, Allen, H.E., et al. editors. Lewis Publishers.

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Ham. R.K. & Booker, T.J. (1982) "Decomposition of Solid Waste in Test Lysimeters." Journal of Environmental Engineering, 108, pp. 1147-1170.

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Kjeldsen, P., Barlaz, M.A., Rooker, A.P., Baun, A. Ledin, A. Christensen; T.H., 2002, "Present and Long-Term Composition of MSW Landfill Leachate: A Review," Environmental Science and Technology, 32(4); 297-336.

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Suthersan, S.S., 1997. Remediation Engineering. Boca Raton, Florida: Lewis Publishers.

7) Will this rulemaking replace any emergency rulemaking currently in effect? No

8) Does this rulemaking contain an automatic repeal date? No

9) Does this rulemaking contain incorporations by reference? Yes

10) Are there any other proposed rulemakings pending on this Part? No

11) Statement of Statewide Policy Objectives: This proposed rulemaking does not create or enlarge a State mandate, as defined in Section 3(b) of the State Mandates Act [30 ILCS 805/3(b) (2004)].

12) Time, Place, and Manner in which interested persons may comment on this proposed rulemaking: The Board held hearings in this rulemaking in Chicago on January 29, 2007 and in Springfield on February 28, 2007. The Board will continue to accept written public comment on this proposal for 45 days after the date of publication in the *Illinois Register*. Comments should reference Docket R07-8 and be addressed to:

Clerk's Office
Illinois Pollution Control Board
100 W. Randolph St., Suite 11-500
Chicago, IL 60601

Interested persons may request copies of the Board's opinion and order by calling the Clerk's office at 312-814-3620, or download from the Board's Web site at www.ipcb.state.il.us.

For more information contact Tim Fox at 312/814-6085 or email at foxt@ipcb.state.il.us.

13) Initial Regulatory Flexibility Analysis:

A) Types of small businesses, small municipalities and not for profit corporations affected: This rulemaking will impact any small businesses, small municipalities

and not for profit corporations that own or operate a solid waste disposal facility.

B) Reporting, bookkeeping or other procedures required for compliance: This rulemaking updates provisions related to reporting, bookkeeping and other procedures.

C) Types of Professional skills necessary for compliance: No professional skills beyond those currently required by the existing state regulations applicable to affected sources will be required.

14) Regulatory Agenda on which this rulemaking was summarized: July 2007

The full text of the Proposed Amendments begins on the next page:

POLLUTION CONTROL BOARD

NOTICE OF PROPOSED AMENDMENTS

TITLE 35: ENVIRONMENTAL PROTECTION
SUBTITLE G: WASTE DISPOSAL
CHAPTER I: POLLUTION CONTROL BOARD
SUBCHAPTER i: SOLID WASTE AND SPECIAL WASTE HAULING

PART 811
STANDARDS FOR NEW SOLID WASTE LANDFILLS

SUBPART A: GENERAL STANDARDS FOR ALL LANDFILLS

Section
811.101 Scope and Applicability
811.102 Location Standards
811.103 Surface Water Drainage
811.104 Survey Controls
811.105 Compaction
811.106 Daily Cover
811.107 Operating Standards
811.108 Salvaging
811.109 Boundary Control
811.110 Closure and Written Closure Plan
811.111 Postclosure Maintenance
811.112 Recordkeeping Requirements for MSWLF Units
811.113 Electronic Reporting

SUBPART B: INERT WASTE LANDFILLS

Section
811.201 Scope and Applicability
811.202 Determination of Contaminated Leachate
811.203 Design Period
811.204 Final Cover
811.205 Final Slope and Stabilization
811.206 Leachate Sampling
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SUBPART C: PUTRESCIBLE AND CHEMICAL WASTE LANDFILLS

Section

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811.302 Facility Location
811.303 Design Period
811.304 Foundation and Mass Stability Analysis
811.305 Foundation Construction
811.306 Liner Systems
811.307 Leachate Drainage System
811.308 Leachate Collection System
811.309 Leachate Treatment and Disposal System
811.310 Landfill Gas Monitoring
811.311 Landfill Gas Management System
811.312 Landfill Gas Processing and Disposal System
811.313 Intermediate Cover
811.314 Final Cover System
811.315 Hydrogeologic~~Hydrogeological~~ Site Investigations
811.316 Plugging and Sealing of Drill Holes
811.317 Groundwater Impact Assessment
811.318 Design, Construction, and Operation of Groundwater Monitoring Systems
811.319 Groundwater Monitoring Programs
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811.322 Final Slope and Stabilization
811.323 Load Checking Program
811.324 Corrective Action Measures for MSWLF Units
811.325 Selection of remedy for MSWLF Units
811.326 Implementation of the corrective action program at MSWLF Units

SUBPART D: MANAGEMENT OF SPECIAL WASTES AT LANDFILLS

Section
811.401 Scope and Applicability
811.402 Notice to Generators and Transporters
811.403 Special Waste Manifests
811.404 Identification Record
811.405 Recordkeeping Requirements
811.406 Procedures for Excluding Regulated Hazardous Wastes

SUBPART E: CONSTRUCTION QUALITY ASSURANCE PROGRAMS

POLLUTION CONTROL BOARD

NOTICE OF PROPOSED AMENDMENTS

Section
811.501 Scope and Applicability
811.502 Duties and Qualifications of Key Personnel
811.503 Inspection Activities
811.504 Sampling Requirements
811.505 Documentation
811.506 Foundations and Subbases
811.507 Compacted Earth Liners
811.508 Geomembranes
811.509 Leachate Collection Systems

SUBPART G: FINANCIAL ASSURANCE

Section
811.700 Scope, Applicability and Definitions
811.701 Upgrading Financial Assurance
811.702 Release of Financial Institution
811.703 Application of Proceeds and Appeals
811.704 Closure and Postclosure Care Cost Estimates
811.705 Revision of Cost Estimate
811.706 Mechanisms for Financial Assurance
811.707 Use of Multiple Financial Mechanisms
811.708 Use of a Financial Mechanism for Multiple Sites
811.709 Trust Fund for Unrelated Sites
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811.APPENDIX A Financial Assurance Forms
811.ILLUSTRATION A Trust Agreement
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811.ILLUSTRATION C	Forfeiture Bond
811.ILLUSTRATION D	Performance Bond
811.ILLUSTRATION E	Irrevocable Standby Letter of Credit
811.ILLUSTRATION F	Certificate of Insurance for Closure and/or Postclosure Care
811.ILLUSTRATION G	Operator's Bond Without Surety
811.ILLUSTRATION H	Operator's Bond With Parent Surety
811.ILLUSTRATION I	Letter from Chief Financial Officer
811.APPENDIX B	Section-by-Section correlation between the Standards of the RCRA Subtitle D MSWLF regulations and the Board's nonhazardous waste landfill regulations.
811.APPENDIX C	List of Leachate Monitoring Parameters

AUTHORITY: Implementing Sections 7.2, 21, 21.1, 22, 22.17, and 22.40 and authorized by Section 27 of the Environmental Protection Act [415 ILCS 5/7.2, 21, 21.1, 22, 22.17, 22.40, and 27].

SOURCE: Adopted in R88-7 at 14 Ill. Reg. 15861, effective September 18, 1990; amended in R92-19 at 17 Ill. Reg. 12413, effective July 19, 1993; amended in R93-10 at 18 Ill. Reg. 1308, effective January 13, 1994; expedited correction at 18 Ill. Reg. 7504, effective July 19, 1993; amended in R90-26 at 18 Ill. Reg. 12481, effective August 1, 1994; amended in R95-13 at 19 Ill. Reg. 12257, effective August 15, 1995; amended in R96-1 at 20 Ill. Reg. 12000, effective August 15, 1996; amended in R97-20 at 21 Ill. Reg. 15831, effective November 25, 1997; amended in R98-9 at 22 Ill. Reg. 11491, effective June 23, 1998; amended in R99-1 at 23 Ill. Reg. 2794, effective February 17, 1999; amended in R98-29 at 23 Ill. Reg. 6880, effective July 1, 1999; amended in R04-5/R04-15 at 28 Ill. Reg. 9107, effective June 18, 2004; amended in R05-1 at 29 Ill. Reg. 5044, effective March 22, 2005; amended in R06-5/R06-6/R06-7 at 30 Ill. Reg. 4136, effective February 23, 2006; amended in R06-16/R06-17/R06-18 at 31 Ill. Reg. 1435, effective December 20, 2006; amended in R07-8 at 31 Ill. Reg. _____, effective _____.

SUBPART C: PUTRESCIBLE AND CHEMICAL WASTE LANDFILLS

Section 811.309 Leachate Treatment and Disposal Systems

a) Leachate shall be allowed to flow freely from the drainage and collection system. The operator is responsible for the operation of a leachate management system designed to handle all leachate as it drains from the collection system. The leachate management system shall consist of any combination of storage, treatment, pretreatment, and disposal options designed and constructed in

compliance with the requirements of this Section.

b) The leachate management system shall consist of any combination of multiple treatment and storage structures, to allow the management and disposal of leachate during routine maintenance and repairs.

c) Standards for Onsite Treatment and Pretreatment

1) All onsite treatment or pretreatment systems shall be considered part of the facility.

2) The onsite treatment or pretreatment system shall be designed in accordance with the expected characteristics of the leachate. The design may include modifications to the system necessary to accommodate changing leachate characteristics.

3) The onsite treatment or pretreatment system shall be designed to function for the entire design period.

4) All of the facility's unit operations, tanks, ponds, lagoons and basins shall be designed and constructed with liners or containment structures to control seepage to groundwater.

5) All treated effluent discharged to waters of the State shall meet the requirements of 35 Ill. Adm. Code 309.

6) The treatment system shall be operated by an operator certified under the requirements of 35 Ill. Adm. Code 312.

d) Standards for Leachate Storage Systems

1) Except as otherwise provided in subsection (d)(6) of this Section, the leachate storage facility must be able to store a minimum of at least five days' worth of accumulated leachate at the maximum generation rate used in designing the leachate drainage system in accordance with Section 811.307. The minimum storage capacity may be built up over time and in stages, so long as the capacity for five consecutive days of accumulated leachate is available at any time during the design period of the facility.

2) All leachate storage tanks shall be equipped with secondary containment systems equivalent to the protection provided by a clay liner 0.61 meter (2 feet thick) having a permeability no greater than 10^{-7} centimeters per second.

3) Leachate storage systems shall be fabricated from material compatible with the leachate expected to be generated and resistant to temperature extremes.

4) The leachate storage system shall not cause or contribute to a malodor.

5) The leachate drainage and collection system shall not be used for the purpose of storing leachate.

6) A facility may have less than five days' worth of storage capacity for accumulated leachate as required by subsection (d)(1) of this Section, if the owner or operator of the facility demonstrates that multiple treatment, storage and disposal options in the facility's approved leachate management system developed in accordance with subsection (b) of this Section will achieve equivalent performance. Such options shall consist of not less than one day's worth of storage capacity for accumulated leachate plus at least two alternative means of managing accumulated leachate through treatment or disposal, or both treatment and disposal, each of which means is capable of treating or disposing of all leachate generated at the maximum generation rate on a daily basis.

e) Standards for Discharge to an Offsite Treatment Works

1) Leachate may be discharged to an offsite treatment works that meets the following requirements:

A) All discharges of effluent from the treatment works shall meet the requirements of 35 Ill. Adm. Code 309.

B) The treatment systems shall be operated by an operator certified under the requirements of 35 Ill. Adm. Code 312.

C) No more than 50 percent of the average daily influent flow can be attributable to leachate from the solid waste disposal facility.

Otherwise, the treatment works shall be considered a part of the solid waste disposal facility.

2) The operator is responsible for securing permission from the offsite treatment works for authority to discharge to the treatment works.

3) All discharges to a treatment works shall meet the requirements of 35 Ill. Adm. Code 310.

4) Pumps, meters, valves and monitoring stations that control and monitor the flow of leachate from the unit and which are under the control of the operator shall be considered part of the facility and shall be accessible to the operator at all times.

5) Leachate shall be allowed to flow into the sewage system at all times; however, if access to the treatment works is restricted or anticipated to be restricted for longer than five days, then an alternative leachate management system shall be constructed in accordance with subsection (c).

6) Where leachate is not directly discharged into a sewerage system, the operator shall provide storage capacity sufficient to transfer all leachate to an offsite treatment works. The storage system shall meet the requirements of subsection (d).

f) Standards for Leachate Recycling Systems

1) Leachate recycling systems may be utilized only at permitted waste disposal units that meet the following requirements:

A) The unit must have a liner designed, constructed and maintained to meet the minimum standards of Section 811.306.

B) The unit must have a leachate collection system in place and operating in accordance with Section 811.307.

C) A gas management system, equipped with a mechanical device such as a compressor to withdraw gas, must be implemented to control odors and prevent migration of methane in accordance with

Section 811.311.

D) The topography must be such that any accidental leachate runoff can be controlled by ditches, berms or other equivalent control means.

2) Leachate shall not be recycled during precipitation events or in volumes large enough to cause runoff or surface seeps.

3) The amount of leachate added to the unit shall not exceed the ability of the waste and cover soils to transmit leachate flow downward. All other leachate shall be considered excess leachate, and a leachate management system capable of disposing of all excess leachate must be available.

4) The leachate storage and distribution system shall be designed to avoid exposure of leachate to air unless aeration or functionally equivalent devices are utilized.

5) The distribution system shall be designed to allow leachate to be evenly distributed beneath the surface over the recycle area.

6) Daily and intermediate cover shall be permeable to the extent necessary to prevent the accumulation of water and formation of perched watertables and gas buildup; alternatively cover shall be removed prior to additional waste placement.

7) Daily and intermediate cover shall slope away from the perimeter of the site to minimize surface discharges.

g) Leachate Monitoring

1) Representative samples of leachate shall be collected from each established leachate monitoring location ~~and tested~~ in accordance with subsection~~subsections~~ (g)(5) and tested for the parameters referenced in subsections (g)(2)(G) and (g)(3)(D).~~at a frequency of once per quarter until such time as samples have been obtained and tested for at least eight quarters. If for any reason insufficient leachate is obtained to yield a sample for testing during a given quarterly monitoring attempt, such attempt shall not count toward the eight quarters' leachate monitoring~~

~~requirement. Thereafter, the frequency of testing shall be changed to semi-annual for any monitored constituent while the leachate management system is in operation. However,~~ The~~the~~ Agency may, by permit condition, require additional, or allow less, leachate sampling and testing as necessary to ensure compliance with this Section and Sections 811.312, 811.317, and 811.319.

2) Discharges of leachate from units that dispose of putrescible wastes shall be tested for the following constituents prior to treatment or pretreatment:

A) Five day biochemical oxygen demand (BOD_5);

B) Chemical oxygen demand;

C) Total Suspended Solids;

D) Total Iron;

E) pH;

F) Any other constituents listed in the operator's National Pollution Discharge Elimination System (NPDES) discharge permit, pursuant to 35 Ill. Adm. Code 304, or required by a publicly owned treatment works, pursuant to 35 Ill. Adm. Code 310; and

G) All the monitoring parameters listed in Section 811.Appendix C, unless an alternate monitoring list has been approved by the Agency~~of the indicator constituents chosen in accordance with Section 811.319(a)(2)(B) and used by the operator for groundwater monitoring~~.

3) Discharges of leachate from units which dispose only chemical wastes shall be monitored for constituents determined by the characteristics of the chemical waste to be disposed of in the unit. They shall include, as a minimum:

A) pH;

B) Total Dissolved Solids;

C) Any other constituents listed in the operator's NPDES discharge permit, pursuant to 35 Ill. Adm. Code 304, or required by a publicly owned treatment works, pursuant to 35 Ill. Adm. Code 310; and

D) All the monitoring parameters listed in Section 811.Appendix C, unless an alternate monitoring list has been approved by the Agency~~of the indicator constituents chosen in accordance with Section 811.319(a)(2)(B) and used by the operator for groundwater monitoring~~.

4) A network of leachate monitoring locations shall be established, capable of characterizing the leachate produced by the unit. Unless an alternate network has been approved by the Agency, the network of leachate monitoring locations shall include:

A) At least four leachate monitoring locations; and

B) At least one leachate monitoring location for every 25 acres within the unit's waste boundaries.

5) Leachate monitoring shall be performed at least once every six months and each established leachate monitoring location shall be monitored at least once every two years.

h) Time of Operation of the Leachate Management System

1) The operator shall collect and dispose of leachate for a minimum of five years after closure and thereafter until treatment is no longer necessary.

2) Treatment is no longer necessary if the leachate constituents do not exceed the wastewater effluent standards in 35 Ill. Adm. Code 304.124, 304.125, 304.126 and do not contain a BOD_5 concentration greater than 30 mg/L for six consecutive months.

3) Leachate collection at a MSWLF unit shall be continued for a minimum period of 30 years after closure, except as otherwise provided by subsections (h)(4) and (h)(5)~~, below~~.

4) The Agency may reduce the leachate collection period at a MSWLF unit upon a demonstration by the owner or operator that the reduced period is sufficient to protect human health and environment.

5) The owner or operator of a MSWLF unit shall petition the Board for an adjusted standard in accordance with Section 811.303, if the owner or operator seeks a reduction of the postclosure care monitoring period for all of the following requirements:

i) Inspection and maintenance (Section 811.111);

ii) Leachate collection (Section 811.309);

iii) Gas monitoring (Section 811.130); and

iv) Groundwater monitoring (Section 811.319).

BOARD NOTE: Subsection (h) is derived from 40 CFR 258.61 (1992).

(Source: Amended at 31 Ill. Reg. _____, effective _____)

Section 811.315 Hydrogeologic Site Investigations

a) Purpose
The operator shall conduct a hydrogeologic investigation to develop hydrogeologic information for the following uses:

1) Provide information to perform a groundwater impact assessment; and

2) Provide information to establish a groundwater monitoring system.

b) General Requirements

1) The investigation shall be conducted in a minimum of three phases prior to submission of any application to the Agency for a permit to develop and operate a landfill facility.

2) The study area shall consist of the entire area occupied by the facility and

any adjacent related areas, if necessary for the purposes of the hydrogeological investigation set forth in subsection (a).

3) All borings shall be sampled continuously at all recognizable points of geologic variation, except that where continuous sampling is impossible or where non-continuous sampling can provide equivalent information, samples shall be obtained at intervals no greater than 1.52 meters (five feet) in homogeneous strata.

c) Minimum Requirements for a Phase I Investigation

1) The operator shall conduct a Phase I Investigation to develop the following information:

A) Climatic aspects of the study area;

B) The regional and study area geologic setting, including a description of the geomorphology and stratigraphy of the area;

C) The regional groundwater regime including water table depths and aquifer characteristics; and

D) Information for the purpose of designing a Phase II Hydrogeologic Investigation.

2) Specific Requirements

A) The regional hydrogeologic setting of the unit shall be established by using material available from all possible sources, including, but not limited to, the Illinois Scientific Surveys, the Agency, other State and Federal organizations, water well drilling logs, and previous investigations.

B) A minimum of one continuously sampled boring shall be drilled on the site, as close as feasible to the geographic center, to determine if the available regional hydrogeologic setting information is accurate and to characterize the site-specific hydrogeology to the extent specified by this phase of the investigation. The boring shall extend at least 15.2 meters (50 feet) below the bottom of the

uppermost aquifer or through the full depth of the confining layer below the uppermost aquifer, or to bedrock, if the bedrock is below the upper most aquifer, whichever elevation is higher. The locations of any additional borings, required under this subsection, may be chosen by the investigator, but shall be sampled continuously.

d) Minimum Requirements for a Phase II Investigation

1) Information to be developed
Using the information developed in the Phase I survey, a Phase II study shall be conducted to collect the site-specific information listed below as needed to augment data collected during the Phase I investigation and to prepare for the Phase III investigation:

A) Structural characteristics and distribution of underlying strata including bedrock;

B) Chemical and physical properties including, but not limited to, lithology, mineralogy, and hydraulic characteristics of underlying strata including those below the uppermost aquifer;

C) Soil characterisitics, including soil types, distribution, geochemical and geophysical characteristics;

D) The hydraulic conductivities of the uppermost aquifer and all strata above it;

E) The vertical extent of the uppermost aquifer;

F) The direction and rate of groundwater flow.

2) Specific Requirements

A) One boring shall be located as close as feasible to the topographical high point, and another shall be located as close as feasible to the topographical low point of the study area.

B) At least one boring shall be at or near each corner of the site.

Where the property is irregularly shaped the borings shall be located near the boundary in a pattern and spacing necessary to obtain data over the entire study area.

C) Additional borings may be located at intermediate points at locations and spacings necessary to establish the continuity of the stratigraphic units.

D) Piezometers and groundwater monitoring wells shall be established to determine the direction and flow characteristics of the groundwater in all strata and extending down to the bottom of the uppermost aquifer. Groundwater samples taken from such monitoring wells shall be used to develop preliminary information needed for establishing background concentrations in accordance with subsection (e)(1)(G).

E) Other methods may be utilized to confirm or accumulate additional information. Such methods may be used only as a supplement to, not in lieu of, site-specific boring information. Other methods include, but are not limited to, geophysical well logs, geophysical surveys, aerial photography, age dating, and test pits.

e) Minimum Standards For A Phase III Investigation

1) Using the information developed during the Phase I and Phase II Investigations, the operator shall conduct a Phase III Investigation. This investigation shall be conducted to collect or augment the site-specific information needed to carry out the following:

A) Verification and reconciliation of the information collected in the Phase I and II investigations;

B) Characterization of potential pathways for contaminant migration;

C) Correlation of stratigraphic units between borings;

D) Continuity of petrographic features including, but not limited to, sorting, grain size distribution, cementation and hydraulic conductivity;

E) Identification of zones of potentially high hydraulic conductivity;

F) Identification of the confining layer, if present;

G) Concentrations of chemical constituents present in the groundwater below the unit, down to the bottom of the uppermost aquifer, using a broad range of chemical analysis and detection procedures such as, gas chromatographic and mass spectrometric scanning. However, additional measurements and procedures shall be carried out to establish background concentrations, in accordance with Section 811.320(d), for:

i) Any constituent for which there is a ~~public or food processing water supply~~ standard at 35 Ill. Adm. Code 620~~302~~ established by the Board and which is expected to appear in the leachate; and

ii) Any other constituent for which there is no Board-established standard, but which is expected to appear in the leachate at concentrations above PQL, as defined in Section 811.319(a)(4)(A) for that constituent;

H) Characterization of the seasonal and temporal, naturally and artificially induced, variations in groundwater quality and groundwater flow; and

I) Identification of unusual or unpredicted geologic features, including: fault zones, fracture traces, facies changes, solution channels, buried stream deposits, cross cutting structures and other geologic features that may affect the ability of the operator to monitor the groundwater or predict the impact of the disposal facility on groundwater.

2) In addition to the specific requirements applicable to Phase~~phase~~ I and II investigations, the operator shall collect information needed to meet the minimum standards of a Phase~~phase~~ III investigation by using methods that may include, but not limited to excavation of test pits, additional borings located at intermediate points between boreholes placed during

Phase~~phase~~ I and II investigations, placement of piezometers and monitoring wells, and institution of procedures for sampling and analysis.

f) The operator may conduct the hydrogeologic investigation in any number of alternative ways provided that the necessary information is collected in a systematic sequence consisting of at least three phases that is equal to or superior to the investigation procedures of this Section.

(Source: Amended at 31 Ill. Reg. _____, effective _____)

Section 811.318 Design, Construction, and Operation of Groundwater Monitoring Systems

a) All potential sources of discharges to groundwater within the facility, including, but not limited to, all waste disposal units and the leachate management system, shall be identified and studied through a network of monitoring wells operated during the active life of the unit and for the time after closure specified in accordance with Section 811.319. Monitoring wells designed and constructed as part of the monitoring network shall be maintained along with records that include, but are not limited to, exact well location, well size, type of well, the design and construction practice used in its installation and well and screen depths.

b) Standards for the Location of Monitoring Points

1) A network of monitoring points shall be established at sufficient locations downgradient with respect to groundwater flow and not excluding the downward direction, to detect any discharge of contaminants from any part of a potential source of discharge.

2) Monitoring wells shall be located in stratigraphic horizons that could serve as contaminant migration pathways.

3) Monitoring wells shall be established as close to the potential source of discharge as possible without interfering with the waste disposal operations, and within half the distance from the edge of the potential source of discharge to the edge of the zone of attenuation downgradient, with respect to groundwater flow, from the source.

4) The network of monitoring points of several potential sources of discharge

within a single facility may be combined into a single monitoring network, provided that discharges from any part of all potential sources can be detected.

5) A minimum of at least one monitoring well shall be established at the edge of the zone of attenuation and shall be located downgradient with respect to groundwater flow and not excluding the downward direction, from the unit. Such well or wells shall be used to monitor any statistically significant increase in the concentration of any constituent, in accordance with Section 811.320(e) and shall be used for determining compliance with an applicable groundwater quality standard of Section 811.320. An observed statistically significant increase above the applicable groundwater quality standards of Section 811.320 in a well located at or beyond the compliance boundary shall constitute a violation.

c) Maximum Allowable Predicted Concentrations
The operator shall use the same calculation methods, data, and assumptions as used in the groundwater impact assessment to predict the concentration over time and space of all constituents chosen to be monitored in accordance with Section 811.319 at all monitoring points. The predicted values shall be used to establish the maximum allowable predicted concentrations (MAPC) at each monitoring point. The MAPCs calculated in this subsection shall be applicable within the zone of attenuation.

d) Standards for Monitoring Well Design and Construction

1) All monitoring wells shall be cased in a manner that maintains the integrity of the bore hole. The casing material shall be inert so as not to affect the water sample. Casing requiring solvent-cement type couplings shall not be used.

2) Wells shall be screened to allow sampling only at the desired interval. Annular space between the borehole wall and well screen section shall be packed with gravel sized to avoid clogging by the material in the zone being monitored. The slot size of the screen shall be designed to minimize clogging. Screens shall be fabricated from material expected to be inert with respect to the constituents of the groundwater to be sampled.

3) Annular space above the well screen section shall be sealed with a

relatively impermeable, expandable material such as a cement/bentonite grout, which does not react with or in any way affect the sample, in order to prevent contamination of samples and groundwater and avoid interconnections. The seal shall extend to the highest known seasonal groundwater level.

4) The annular space shall be back-filled with expanding cement grout from an elevation below the frost line and mounded above the surface and sloped away from the casing so as to divert surface water away.

5) The annular space between the upper and lower seals and in the unsaturated zone may be back-filled with uncontaminated cuttings.

6) All wells shall be covered with vented caps and equipped with devices to protect against tampering and damage.

7) All wells shall be developed to allow free entry of water, minimize turbidity of the sample, and minimize clogging.

8) The transmissivity of the zone surrounding all well screens shall be established by field testing techniques.

9) Other sampling methods and well construction techniques may be utilized if they provide equal or superior performance to the requirements of this subsection.

e) Standards for Sample Collection and Analysis

1) The groundwater monitoring program shall include consistent sampling and analysis procedures to assure that monitoring results can be relied upon to provide data representative of groundwater quality in the zone being monitored.

2) The operator shall utilize procedures and techniques to insure that collected samples are representative of the zone being monitored and that prevent cross contamination of samples from other monitoring wells or from other samples. At least 95 percent of a collected sample shall consist of groundwater from the zone being monitored.

3) The operator shall establish a quality assurance program that provides quantitative detection limits and the degree of error for analysis of each chemical constituent.

4) The operator shall establish a sample preservation and shipment procedure that maintains the reliability of the sample collected for analysis.

5) The operator shall institute a chain of custody procedure to prevent tampering and contamination of the collected samples prior to completion of analysis.

6) At a minimum, the operator shall sample the following parameters at all wells at the time of sample collection and immediately before filtering and preserving samples for shipment:

A) The elevation of the water table;

~~B) The depth of the well below ground;~~

B~~C~~) pH;

C~~D~~) The temperature of the sample; and

D~~E~~) Specific Conductance.

7) The operator must measure the depth of the well below ground on an annual basis, at wells that do not contain dedicated pumps. The operator must measure the depth of the well below ground every 5 years, or whenever the pump is pulled, in wells with dedicated pumps.

8~~7~~) In addition to the requirements of subsections (e)(1) through (e)(6), the following requirements shall apply to MSWLF units:

A) Each time groundwater is sampled, an owner or operator of a MSWLF unit shall:

i) Measure the groundwater elevations in each well immediately prior to purging; and

ii) Determine the rate and direction of ground-water flow.

B) An owner or operator shall measure groundwater elevations in wells which monitor the same waste management area within a period of time short enough to avoid temporal variations in groundwater flow which could preclude accurate determination of groundwater flow rate and direction.

BOARD NOTE: Subsection (e)(7) is derived from 40 CFR 258.53(d) (1992).

(Source: Amended at 31 Ill. Reg. _____, effective _____)

Section 811.319 Groundwater Monitoring Programs

a) Detection Monitoring Program
Any use of the term maximum allowable predicted concentration in this Section is a reference to Section 811.318(c). The operator shall implement a detection monitoring program in accordance with the following requirements:

1) Monitoring Schedule and Frequency

A) The monitoring period shall begin as soon as waste is placed into the unit of a new landfill or within one year of the effective date of this Part for an existing landfill. Monitoring shall continue for a minimum period of fifteen years after closure, or in the case of MSWLF units, a minimum period of 30 years after closure, except as otherwise provided by subsection (a)(1)(C) of this Section. The operator shall sample all monitoring points for all potential sources of contamination on a quarterly basis except as specified in subsection (a)(3), for a period of five years from the date of issuance of the initial permit for significant modification under 35 Ill. Adm. Code 814.104 or a permit for a new unit pursuant to 35 Ill. Adm. Code 813.104. After the initial five-year period, the sampling frequency for each monitoring point shall be reduced to a semi-annual basis, provided the operator has submitted the certification described in 35 Ill. Adm. Code 813.304(b). Alternatively, after the initial five-year period, the Agency shall allow sampling on a semi-annual basis where the operator

demonstrates that monitoring effectiveness has not been compromised, that sufficient quarterly data has been collected to characterize groundwater, and that leachate from the monitored unit does not constitute a threat to groundwater. For the purposes of this Section, the source shall be considered a threat to groundwater if the results of the monitoring indicate either that the concentrations of any of the constituents monitored within the zone of attenuation is above the maximum allowable predicted concentration for that constituent or, for existing landfills, subject to 35 Ill. Adm. Code 814, Subpart D, that the concentration of any constituent has exceeded the applicable standard at the compliance boundary as defined in 35 Ill. Adm. Code 814.402(b)(3).

B) Beginning fifteen years after closure of the unit, or five years after all other potential sources of discharge no longer constitute a threat to groundwater, as defined in subsection (a)(1)(A), the monitoring frequency may change on a well by well basis to an annual schedule if either of the following conditions exist. However, monitoring shall return to a quarterly schedule at any well where a statistically significant increase is determined to have occurred in accordance with Section 811.320(e), in the concentration of any constituent with respect to the previous sample.

i) All constituents monitored within the zone of attenuation have returned to a concentration less than or equal to ten percent of the maximum allowable predicted concentration; or

ii) All constituents monitored within the zone of attenuation are less than or equal to their maximum allowable predicted concentration for eight consecutive quarters.

C) Monitoring shall be continued for a minimum period of: 30~~thirty~~ years after closure at MSWLF units, except as otherwise provided by subsections (a)(1)(D) and (a)(1)(E)~~, below~~; five years after closure at landfills, other than MSWLF units, which are used exclusively for disposing waste generated at the site; or 15~~fifteen~~ years after closure at all other landfills regulated under this Part. Monitoring, beyond the minimum period, may be discontinued

under the following conditions:

i) No statistically significant increase is detected in the concentration of any constituent above that measured and recorded during the immediately preceding scheduled sampling for three consecutive years, after changing to an annual monitoring frequency; or

ii) Immediately after contaminated leachate is no longer generated by the unit.

D) The Agency may reduce the groundwater monitoring period at a MSWLF unit upon a demonstration by the owner or operator that the reduced period is sufficient to protect human health and environment.

E) An owner or operator of a MSWLF unit shall petition the Board for an adjusted standard in accordance with Section 811.303, if the owner or operator seeks a reduction of the postclosure care monitoring period for all of the following requirements:

i) Inspection and maintenance (Section 811.111);

ii) Leachate collection (Section 811.309);

iii) Gas monitoring (Section 811.310); and

iv) Groundwater monitoring (Section 811.319).

BOARD NOTE: Changes to subsections (a)(1)(A) and (a)(1)(C), and subsections (a)(1)(D) and (a)(1)(E) are derived from 40 CFR 258.61 (1992).

2) Criteria for Choosing Constituents to be Monitored

A) The operator shall monitor each well for constituents that will provide a means for detecting groundwater contamination. Constituents shall be chosen for monitoring if they meet the following requirements:

i) The constituent appears in, or is expected to be in, the leachate; and

ii) Is contained within the following list of constituents:

Ammonia – Nitrogen (dissolved)
Arsenic (dissolved)
Boron (dissolved)
Cadmium (dissolved)
Chloride (dissolved)
Chromium (dissolved)
Cyanide (total)
Lead (dissolved)
Magnesium (dissolved)
Mercury (dissolved)
Nitrate (dissolved)
Sulfate (dissolved)
Total Dissolved Solids (TDS)
Zinc (dissolved)

iii) This is the minimum list for MSWLFs.

iv) Any facility accepting more than 50% by volume non-municipal must determine additional indicator parameters based upon leachate characteristic and waste content.

~~ii) The Board has established for the constituent a public or food processing water supply standard, at 35 Ill. Adm. Code 302, the Board has established a groundwater quality standard under the Illinois Groundwater Protection Act [415 ILCS 55], or the constituent may otherwise cause or contribute to groundwater contamination.~~

B) One or more indicator constituents, representative of the transport processes of constituents in the leachate, may be chosen for monitoring in place of the constituents it represents. The use of such indicator constituents must be included in an Agency approved permit.

3) Organic Chemicals Monitoring
The operator shall monitor each existing well that is being used as a part of the monitoring well network at the facility within one year of the effective date of this Part, and monitor each new well within the three months of its establishment. The monitoring required by this subsection (a)(3) shall be for a broad range of organic chemical contaminants in accordance with the procedures described below:

A) The analysis shall be at least as comprehensive and sensitive as the tests for the;~~i)The~~ 51 organic chemicals in drinking water described at 40 CFR 141.40 (1988) and 40 CFR 258.Appendix I (2006), incorporated by reference at 35 Ill. Adm. Code 810.104~~;~~ and:

Acetone
Acrylonitrile
Benzene
Bromobenzene
Bromochloromethane
Bromodichloromethane
Bromoform; Tribromomethane
n-Butylbenzene
sec-Butylbenzene
tert-Butylbenzene
Carbon disulfide
Carbon tetrachloride
Chlorobenzene
Chloroethane
Chloroform; Trichloromethane
o-Chlorotoluene
p-Chlorotoluene
Dibromochloromethane
1,2-Dibromo-3-chloropropane

1,2-Dibromoethane
1,2-Dichlorobenzene
1,3-Dichlorobenzene
1,4-Dichlorobenzene
trans-1,4-Dichloro-2-butene
Dichlorodifluoromethane
1,1-Dichloroethane
1,2-Dichloroethane
1,1-Dichloroethylene
cis-1,2-Dichloroethylene
trans-1,2-Dicloroethylene
1,2-Dichloropropane
1,3-Dichloropropane
2,2-Dichloropropane
1,1-Dichloropropene
1,3-Dichloropropene
cis-1,3-Dichloropropene
trans-1,3-Dichloropropene
Ethylbenzene
Hexachlorobutadiene
2-Hexanone; Methyl butyl ketone
Isopropylbenzene
p-Isopropyltoluene
Methyl bromide; Bromomethane
Methyl chloride; Chloromethane
Methylene bromide; Dibromomethane
Dichloromethane
Methyl ethyl ketone
Methyl iodide; Iodomethane
4-Methyl-2-pentanone
Naphthalene

Oil and Grease (hexane soluble)
n-Propylbenzene
Styrene
1,1,1,2-Tetrachloroethane
1,1,2,2-Tetrachloroethane
Tetrachloroethylene
Tetrahydrofuran
Toluene
Total Phenolics
1,2,3-Trichlorobenzene
1,2,4-Trichlorobenzene
1,1,1-Trichloroethane
1,1,2-Trichloroethane
Trichloroethylene
Trichlorofluoromethane
1,2,3-Trichloropropane
1,2,4-Trimethylbenzene
1,3,5-Trimethylbenzene
Vinyl acetate
Vinyl chloride
Xylenes

~~ii) Any other organic chemical for which a groundwater quality standard or criterion has been adopted pursuant to Section 14.4 of the Act or Section 8 of the Illinois Groundwater Protection Act.~~

B) At least once every two years, the operator shall monitor each well in accordance with subsection (a)(3~~1~~)(A).

C) The operator of a MSWLF unit shall monitor each well in accordance with subsection (a)(3~~1~~)(A) on a semi-annual~~an annual~~ basis.

BOARD NOTE: Subsection (a)(3)(C) is derived from 40 CFR 258.54(b) (1992).

4) Confirmation of Monitored Increase

A) The confirmation procedures of this subsection shall be used only if the concentrations of the constituents monitored can be measured at or above the practical quantitation limit (PQL). The PQL is defined as the lowest concentration that can be reliably measured within specified limits of precision and accuracy, under routine laboratory operating conditions. The operator shall institute the confirmation procedures of subsection (a)(4)(B) after notifying the Agency in writing, within ten days, of observed increases:

i) The concentration of any inorganic constituent monitored in accordance with subsections~~subsection~~ (a)(1) and (a)(2) shows a progressive increase over eight~~four~~ consecutive monitoring events;

ii) The concentration of any constituent exceeds the maximum allowable predicted concentration at an established monitoring point within the zone of attenuation;

iii) The concentration of any constituent monitored in accordance with subsection (a)(3) exceeds the preceding measured concentration at any established monitoring point; and

iv) The concentration of any constituent monitored at or beyond the zone of attenuation exceeds the applicable groundwater quality standards of Section 811.320.

B) The confirmation procedures shall include the following:

i) The operator shall verify any observed increase by taking additional samples within 90~~45~~ days after~~of~~ the initial sampling event~~observation~~ and ensure that the samples and sampling protocol used will detect any statistically

significant increase in the concentration of the suspect constituent in accordance with Section 811.320(e), so as to confirm the observed increase. The operator shall notify the Agency of any confirmed increase before the end of the next business day following the confirmation.

ii) The operator shall determine the source of any confirmed increase, which may include, but shall not be limited to, natural phenomena, sampling or analysis errors, or an offsite source.

iii) The operator shall notify the Agency in writing of any confirmed increase. The notification must demonstrate a source other than the facility ~~and state the source of the confirmed increase~~ and provide the rationale used in such a determination. The notification must be submitted to the Agency no later than 180 days after the original sampling event. If the facility is permitted by the Agency, the notification must be filed for review as a significant permit modification pursuant to 35 Ill. Adm. Code 813.Subpart B~~within ten days of the determination~~.

iv) If an alternative source demonstration described in subsections (a)(4)(B)(ii) and (iii) of this Section cannot be made, assessment monitoring is required in accordance with subsection (b) of this Section.

v) If an alternative source demonstration, submitted to the Agency as an application, is denied pursuant to 35 Ill. Adm. Code 813.105, the operator must commence sampling for the constituents listed in subsection (b)(5) of this Section, and submit an assessment monitoring plan as a significant permit modification, both within 30 days after the dated notification of Agency denial. The operator must sample the well or wells that exhibited the confirmed increase.

b) Assessment Monitoring

The operator shall begin an assessment monitoring program in order to confirm

that the solid waste disposal facility is the source of the contamination and to provide information needed to carry out a groundwater impact assessment in accordance with subsection (c). The assessment monitoring program shall be conducted in accordance with the following requirements:

1) The assessment monitoring shall be conducted in accordance with this subsection to collect information to assess the nature and extent of groundwater contamination. The owner or operator of a MSWLF unit shall comply with the additional requirements prescribed in subsection (b)(5). The assessment monitoring shall consist of monitoring of additional constituents that might indicate the source and extent of contamination. In addition, assessment monitoring may include any other investigative techniques that will assist in determining the source, nature and extent of the contamination, which may consist of, but need not be limited to:

   A) More frequent sampling of the wells in which the observation occurred;

   B) More frequent sampling of any surrounding wells; and

   C) The placement of additional monitoring wells to determine the source and extent of the contamination.

2) Except as provided for in subsections (a)(4)(B)(iii) and (v) of this Section, the~~The~~ operator of the facility for which assessment monitoring is required shall file the plans for an assessment monitoring program with the Agency. If the facility is permitted by the Agency, then the plans shall be filed for review as a significant permit modification pursuant to 35 Ill. Adm. Code 813.Subpart B within 180 days after the original sampling event. The assessment monitoring program shall be implemented within 180~~90~~ days after~~of~~ the original sampling event~~confirmation of any monitored increase~~ in accordance with subsection (a)(4) or, in the case of permitted facilities, within 45~~90~~ days after~~of~~ Agency approval.

3) If the analysis of the assessment monitoring data shows that the concentration of one or more constituents, monitored at or beyond the zone of attenuation is above the applicable groundwater quality standards of Section 811.320 and is attributable to the solid waste disposal facility,

then the operator shall determine the nature and extent of the groundwater contamination including an assessment of the potential impact on the groundwater should waste continue to be accepted at the facility and shall implement the remedial action in accordance with subsection (d).

4) If the analysis of the assessment monitoring data shows that the concentration of one or more constituents is attributable to the solid waste disposal facility and exceeds the maximum allowable predicted concentration within the zone of attenuation, then the operator shall conduct a groundwater impact assessment in accordance with the requirements of subsection (c).

5) In addition to the requirements of subsection (b)(1), to collect information to assess the nature and extent of groundwater contamination, the following requirements are applicable to MSWLF units:

A) The monitoring of additional constituents pursuant to subsection (b)(1)~~(A)~~ must~~shall~~ include, at a minimum (except as otherwise provided in subsection (b)(5)(E) of this Section), the constituents listed in 40 CFR 258.Appendix II, incorporated by reference at 35 Ill. Adm. Code 810.104 and constituents from 35 Ill. Adm. Code 620.410.

BOARD NOTE: Subsection (b)(5)(A) is derived from 40 CFR 258.55(b) (1992).

B) Within 14 days after~~of~~ obtaining the results of sampling required under subsection (b)(5)(A), the owner or operator shall:

i) Place a notice in the operating record identifying the constituents that have been detected; and

ii) Notify the Agency that such a notice has been placed in the operating record.

BOARD NOTE: Subsection (b)(5)(B) is derived from 40 CFR 258.55(d)(1) (1992).

C) The owner or operator shall establish background concentrations

for any constituents detected pursuant to subsection (b)(5)(A) in accordance with Section 811.320(e).

BOARD NOTE: Subsection (b)(5)(C) is derived from 40 CFR 258.55(d)(3) (1992).

D) Within 90 days after~~of~~ the initial monitoring in accordance with subsection (b)(5)(A), the owner or operator must~~shall~~ monitor for the detected constituents listed in 40 CFR 258.Appendix II and 35 Ill. Adm. Code 620.410 on a semiannual basis during the assessment monitoring. The operator must monitor all the constituents listed in 40 CFR 258.Appendix II and 35 Ill. Adm. Code 620.410 on an annual basis during assessment monitoring.

BOARD NOTE: Subsection (b)(5)(D) is derived from 40 CFR 258.55(d)(2) (1992).

E) The owner or operator may request the Agency to delete any of the 40 CFR 258.Appendix II and 35 Ill. Adm. Code 620.410 constituents by demonstrating to the Agency that the deleted constituents are not reasonably expected to be in or derived from the waste contained in the leachate.

BOARD NOTE: Subsection (b)(5)(E) is derived from 40 CFR 258.55(b) (1992).

F) Within 14 days after~~of~~ finding an exceedance above the applicable groundwater quality standards in accordance with subsection (b)(3), the owner or operator shall:

i) Place a notice in the operating record that identifies the constituents monitored under subsection (b)(1)(D) that have exceeded the groundwater quality standard;

ii) Notify the Agency and the appropriate officials of the local municipality or county within whose boundaries the site is located that such a notice has been placed in the operating record; and

iii) Notify all persons who own land or reside on land that directly overlies any part of the plume of contamination if contaminants have migrated off-site.

BOARD NOTE: Subsection (b)(5)(F) is derived from 40 CFR 258.55(g)(1)(i) through (iii) (1992).

G) If the concentrations of all 40 CFR 258.Appendix II and 35 Ill. Adm. Code 620.410 constituents are shown to be at or below background values, using the statistical procedures in Section 811.320(e), for two consecutive sampling events, the owner or operator shall notify the Agency of this finding and may stop monitoring the 40 CFR 258.Appendix II and 35 Ill. Adm. Code 620.410 constituents.

BOARD NOTE: Subsection (b)(5)(G) is derived from 40 CFR 258.55(e) (1992).

c) Assessment of Potential Groundwater Impact. An operator required to conduct a groundwater impact assessment in accordance with subsection (b)(4) shall assess the potential impacts outside the zone of attenuation that may result from confirmed increases above the maximum allowable predicted concentration within the zone of attenuation, attributable to the facility, in order to determine if there is need for remedial action. In addition to the requirements of Section 811.317, the following shall apply:

1) The operator shall utilize any new information developed since the initial assessment and information from the detection and assessment monitoring programs and such information may be used for the recalibration of the GCT model; and

2) The operator shall submit the groundwater impact assessment and any proposed remedial action plans determined necessary pursuant to subsection (d) to the Agency within 180 days after~~of~~ the start of the assessment monitoring program.

d) Remedial Action. The owner or operator of a MSWLF unit shall conduct corrective action in accordance with Sections 811.324, 811.325, and 811.326. The owner or operator of a landfill facility, other than a MSWLF unit, shall

conduct remedial action in accordance with this subsection.

1) The operator shall submit plans for the remedial action to the Agency. Such plans and all supporting information including data collected during the assessment monitoring shall be submitted within 90 days after~~of~~ determination of either of the following:

A) The~~the~~ groundwater impact assessment, performed in accordance with subsection (c), indicates that remedial action is needed; or

B) Any confirmed increase above the applicable groundwater quality standards of Section 811.320 is determined to be attributable to the solid waste disposal facility in accordance with subsection (b).

2) If the facility has been issued a permit by the Agency, then the operator shall submit this information as an application for significant modification to the permit;

3) The operator shall implement the plan for remedial action program within 90 days after~~of~~ the following:

A) Completion of the groundwater impact assessment that requires remedial action;

B) Establishing that a violation of an applicable groundwater quality standard of Section 811.320 is attributable to the solid waste disposal facility in accordance with subsection (b)(3); or

C) Agency approval of the remedial action plan, where the facility has been permitted by the Agency.

4) The remedial action program shall consist of one or a combination of one of more of the following solutions:

A) Retrofit additional groundwater protective measures within the unit;

B) Construct an additional hydraulic barrier, such as a cutoff wall or slurry wall system

C) Pump and treat the contaminated groundwater; or

D) Any other equivalent technique which will prevent further contamination of groundwater.

5) Termination of the Remedial Action Program

A) The remedial action program shall continue in accordance with the plan until monitoring shows that the concentrations of all monitored constituents are below the maximum allowable predicted concentration within the zone of attenuation, below the applicable groundwater quality standards of Section 811.320 at or beyond the zone of attenuation, over a period of four consecutive quarters no longer exist.

B) The operator shall submit to the Agency all information collected under subsection (d)(5)(A). If the facility is permitted then the operator shall submit this information as a significant modification of the permit.

(Source: Amended at 31 Ill. Reg. _____, effective _____)

Section 811.320 Groundwater Quality Standards

a) Applicable Groundwater Quality Standards

1) Groundwater quality shall be maintained at each constituent's background concentration, at or beyond the zone of attenuation. The applicable groundwater quality standard established for any constituent shall be:

A) The background concentration; or

B) The Board established standard adjusted by the Board in accordance with the justification procedure of subsection (b).

2) Any statistically significant increase above an applicable groundwater quality standard established pursuant to subsection (a) that is attributable to the facility and which occurs at or beyond the zone of attenuation

within 100 years after closure of the last unit accepting waste within such a facility shall constitute a violation.

3) For the purposes of this Part:

A) "Background concentration" means that concentration of a constituent that is established as the background in accordance with subsection (d); and

B) "Board established standard" is the concentration of a constituent adopted by the Board as a ~~standard for public and food processing water supplies under 35 Ill. Adm. Code 302 or as a~~ groundwater quality standard adopted by the Board pursuant to Section 14.4 of the Act or Section 8 of the Illinois Groundwater Protection Act~~, whichever is lower~~.

b) Justification for Adjusted Groundwater Quality Standards

1) An operator may petition the Board for an adjusted groundwater quality standard in accordance with the procedures specified in Section 28.1 of the Act and 35 Ill. Adm. Code 104.400, Subpart D~~106.410 through 106.416~~.

2) For groundwater which contains naturally occurring constituents which meet the applicable requirements of 35 Ill. Adm. Code 620.410, 620.420, 620.430, or 620.440~~302.301, 302.304, and 302.305~~, the Board will specify adjusted groundwater quality standards no greater than those of 35 Ill. Adm. Code 620.410, 620.420, 620.430, or 620.440, respectively,~~302.301, 302.304, and 302.305,~~ upon a demonstration by the operator that:

A) The change in standards will not interfere with, or become injurious to, any present or potential beneficial uses for such water;

B) The change in standards is necessary for economic or social development, by providing information including, but not limited to, the impacts of the standards on the regional economy, social disbenefits such as loss of jobs or closing of landfills, and economic analysis contrasting the health and environmental benefits with costs likely to be incurred in meeting the standards; and

C) All technically feasible and economically reasonable methods are being used to prevent the degradation of the groundwater quality.

3) Notwithstanding subsection (b)(2), in no case shall the Board specify adjusted groundwater quality standards for a MSWLF unit greater than the following levels ~~set forth below~~:

Chemical	Concentration (mg/1)
Arsenic	0.05
Barium	1.0
Benzene	0.005
Cadmium	0.01
Carbon tetrachloride	0.005
2,4-Dichlorophenoxy acetic acid	0.05
1,4-Dichlorobenzene	0.1
1,2-Dichloroethane	0.075
1,1-Dichloroethylene	0.005
Endrin	0.007
Fluoride	0.0002
Lindane	4
Lead	0.004
Mercury	0.05
Methoxychlor	0.002
Nitrate	0.1
Selenium	10
Silver	0.01
Toxaphene	0.05
1,1,1-Trichloromethane	0.005
Thrichloroethylene	0.2
2,4,5-Trichlorophenoxy acetic acid	0.005
Vinyl Chloride	0.01

4) For groundwater which contains naturally occurring constituents which do not meet the standards of 35 Ill. Adm. Code 620.410, 620.420, 620.430, or 620.440~~302.301, 302.304, and 302.305~~, the Board will specify adjusted groundwater quality standards, upon a demonstration by the operator that:

A) The groundwater does not presently serve as a source of drinking water;

B) The change in standards will not interfere with, or become injurious to, any present or potential beneficial uses for such waters;

C) The change in standards is necessary for economic or social development, by providing information including, but not limited to, the impacts of the standards on the regional economy, social disbenefits such as loss of jobs or closing of landfills, and economic analysis contrasting the health and environmental benefits with costs likely to be incurred in meeting the standards; and

D) The groundwater cannot presently, and will not in the future, serve as a source of drinking water because:

i) It is impossible to remove water in usable quantities;

ii) The groundwater is situated at a depth or location such that recovery of water for drinking purposes is not technologically feasible or economically reasonable;

iii) The groundwater is so contaminated that it would be economically or technologically impractical to render that water fit for human consumption;

iv) The total dissolved solids content of the groundwater is more than 3,000 mg/l and that water will not be used to serve a public water supply system; or

v) The total dissolved solids content of the groundwater exceeds 10,000 mg/l.

c) Determination of the Zone of Attenuation

1) The zone of attenuation, within which concentrations of constituents in leachate discharged from the unit may exceed the applicable groundwater

quality standard of this Section, is a volume bounded by a vertical plane at the property boundary or 100 feet from the edge of the unit, whichever is less, extending from the ground surface to the bottom of the uppermost aquifer and excluding the volume occupied by the waste.

2) Zones of attenuation shall not extend to the annual high water mark of navigable surface waters.

3) Overlapping zones of attenuation from units within a single facility may be combined into a single zone for the purposes of establishing a monitoring network.

d) Establishment of Background Concentrations

1) The initial monitoring to determine background concentrations shall commence during the hydrogeological assessment required by Section 811.315. The background concentrations for those parameters identified in Sections 811.315(e)(1)(G) and 811.319(a)(2) and (a)(3) shall be established based on consecutive quarterly sampling of wells for a minimum of one year, monitored in accordance with the requirements of subsections (d)(2), (d)(3) and (d)(4). Non-consecutive data may be considered by the Agency, if only one data point from a quarterly event is missing, and it can be demonstrated that the remaining data set is representative of consecutive data in terms of any seasonal or temporal variation~~, which may be adjusted during the operation of a facility.~~ Statistical tests and procedures shall be employed, in accordance with subsection (e), depending on the number, type and frequency of samples collected from the wells, to establish the background concentrations.

2) Adjustments to the background concentrations shall be made ~~only~~ if changes in the concentrations of constituents observed in background ~~upgradient~~ wells over time are determined, in accordance with subsection (e), to be statistically significant, and due to natural temporal or spatial variability or due to an off-site source not associated with the landfill or the landfill activities. Such adjustments may be conducted no more frequently than once every two years during the operation of a facility and modified subject to approval by the Agency. Non-consecutive data may be used for an adjustment upon Agency approval. Adjustments to the background concentration shall not be initiated prior to 2 years after

final rule unless required by the Agency.

3) Background concentrations determined in accordance with this subsection shall be used for the purposes of establishing groundwater quality standards, in accordance with subsection (a). The operator shall prepare a list of the background concentrations established in accordance with this subsection. The operator shall maintain such a list at the facility, shall submit a copy of the list to the Agency for establishing standards in accordance with subsection (a), and shall provide updates to the list within ten days of any change to the list.

4~~2~~) A network of monitoring wells shall be established upgradient from the unit, with respect to groundwater flow, in accordance with the following standards, in order to determine the background concentrations of constituents in the groundwater:

A) The wells shall be located at such a distance that discharges of contaminants from the unit will not be detectable;

B) The wells shall be sampled at the same frequency as other monitoring points to provide continuous background concentration data, throughout the monitoring period; and

C) The wells shall be located at several depths to provide data on the spatial variability.

5~~3~~) A determination of background concentrations may include the sampling of wells that are not hydraulically upgradient of the waste unit where:

A) Hydrogeologic conditions do not allow the owner or operator to determine what wells are hydraulically upgradient of the waste; and

B) Sampling at other wells will provide an indication of background concentrations that is representative of that which would have been provided by upgradient wells.

6~~4~~) If background concentrations cannot be determined on site, then alternative background concentrations may be determined from actual

monitoring data from the aquifer of concern, which includes, but is not limited to, data from another landfill site that overlies the same aquifer.

e) Statistical Analysis of Groundwater Monitoring Data

1) Statistical tests shall be used to analyze groundwater monitoring data. One or more of the normal theory statistical tests ~~listed in subsection (e)(4)~~ shall be chosen first for analyzing the data set or transformations of the data set. Where such normal theory tests are inappropriate, tests listed in subsection (e)(4)~~(5) or a test in accordance with subsection (e)(6)~~ shall be used. The ~~Any statistical test chosen from subsections (e)(4) or (e)(5), the~~ level of significance (Type I error level) shall be no less than 0.01, for individual well comparisons, and no less than 0.05, for multiple well comparisons. The statistical analysis shall include, but not be limited to, the accounting of data below the detection limit of the analytical method used, the establishment of background concentrations and the determination of whether statistically significant changes have occurred in:

A) The concentration of any chemical constituent with respect to the background concentration or maximum allowable predicted concentration; and

B) The established background concentration of any chemical constituents over time.

2) The statistical test or tests used shall be based upon the sampling and collection protocol of Sections 811.318 and 811.319.

3) Monitored data that are below the level of detection shall be reported as not detected (ND). The level of detection for each constituent shall be the practical quantitation limit (PQL), and shall be the lowest~~minimum~~ concentration that is protective of human health and the environment, and can be achieved within specified limits of precision and accuracy during routine laboratory operating conditions. In no case shall the PQL be established above the level that the Board has established for a groundwater quality standard under the Illinois Groundwater Protection Act [415 ILCS 55]. The following procedures shall be used to analyze such data, unless an alternative procedure in accordance with subsection

(e)(4~~6~~), is shown to be applicable:

A) Where the percentage of nondetects in the data base used is less than 15 percent, the operator shall replace NDs with the PQL~~MDL~~ divided by two, then proceed with the use of one or more of the Normal Theory statistical tests~~ listed in subsection (e)(4)~~;

B) Where the percentage of nondetects in the data base ~~or data transformations~~ used is between 15 and 50 percent, and the data are normally distributed, the operator shall use Cohen's or Aitchison's adjustment to the sample mean and standard deviation, followed by an applicable statistical procedure~~one or more of the tests listed in subsection (e)(4)(C). However, where data are not normally distributed, the operator shall use an applicable nonparametric test from subsection (e)(5)~~;

C) Where the percentage of nondetects in the database used is above 50 percent, then the owner or operator shall use an alternative procedure in accordance with~~the test of proportions listed in~~ subsection (e)(4).

4) ~~Normal theory statistical tests:A)Student t-test including, but not limited to, Cochran's Approximation to the Behren Fisher (CABF) t-test and Averaged Replicate (AR) t-test.B)Parametric analysis of variance (ANOVA) followed by one or more of the multiple comparison procedures including, but not limited to, Fisher's Least Significant Difference (LSD), Student Mewman Kuel procedure, Duncan's New Multiple Range Test and Tukey's W procedure.C)Control Charts, Prediction Intervals and Tolerance Intervals, for which the Type I error levels shall be specified by the Agency in accordance with the requirements of 35 Ill. Adm. Code 724.197(i).5)~~Nonparametric statistical tests ~~shall include: Mann-Whitney U-test, Kruskal-Wallis test, a nonparametric analysis of variance (ANOVA) for multiple comparisons or the Wilcoxon Rank Sum test.6)~~or any~~Any~~ other statistical test~~ based on the distribution of the sampling data may be used~~, if it is demonstrated to meet the requirements of 35 Ill. Adm. Code 724.197(i).

BOARD NOTE: Subsection (b)(3) is derived from 40 CFR 258.40 Table 1. (1992).

POLLUTION CONTROL BOARD

NOTICE OF PROPOSED AMENDMENTS

(Source: Amended at 31 Ill. Reg. _____, effective _____)

Section 811.APPENDIX C_List of Leachate Monitoring Parameters

pH
Elevation Leachate Surface
Bottom of Well Elevation
Leachate Level from Measuring Point
Arsenic (total)
Barium (total)
Cadmiun (total) mg/l
Iron (total)
Ammonia Nitrogen – N
Bacteria (Fecal Coliform)
Biochemical Oxygen Demand (BOD_5)
1,1,1,2-Tetrachloroethane
1,1,1-Trichloroethane
1,1,2,2-Tetrachloroethane
1,1,2-Trichloroethane
1,1-Dichloroethane
1,1-Dichloroethylene
1,1-Dichloropropene
1,2,3-Trichlorobenzene
1,2,3-Trichloropropane
1,2,4-Trichlorobenzene
1,2,4-Trimethylbenzene
1,2-Dibromo-3-Chloropropane
1,2-Dichloroethane
1,2-Dichloropropane
1,3,5-Trimethylbenzene
1,3-Dichloropropane
1,3-Dichloropropene
1,4-Dichloro-2-Butene

1-Propanol
2,2-Dichloropropane
2,4,5-tp (Silvex)
2,4,6-Trichlorophenol
2,4-Dichlorophenol
2,4-Dichlorophenoxyacetic Acid (2,4-D)
2,4-Dimethylphenol
2,4-Dinitrotoluene
2,4-Dinitrophenol
2,6-Dinitrotoluene
2-Chloroethyl Vinyl Ether
2-Chloronaphthalene
2-Chlorophenol
2-Hexanone
2-Propanol (Isopropyl Alcohol)
3,3-Dichlorobenzidine
4,4-DDD
4,4-DDE
4,4-DDT
4,6-Dinitro-O-Cresol
4-Bromophenyl Phenyl Ether
4-Chlorophenyl Phenyl Ether
4-Methyl-2-Pentanone
4-Nitrophenol
Acenaphthene
Acetone
Alachlor
Aldicarb
Aldrin
Alpha – BHC

Aluminum
Anthracene
Antimony
Atrazine
Benzene
Benzo (a) Anthracene
Benzo (a) Pyrene
Benzo (b) Fluoranthene
Benzo (ghi) Perylene
Benzo (k) Fluoranthene
Beryllium (total)
Beta – BHC
Bicarbonate
Bis (2-Chloro-1-Methylethyl) Ether
Bis (2-Chloroethoxy) Methane
Bis (2-Chloroethyl) Ether
Bis (2-Ethylhexyl) Ether
Bis (2-Ethylhexyl) Phthalate
Bis(Chloromethyl) Ether
Boron
Bromobenzene
Bromochloromethane
Bromodichloromethane
Bromoform
Bromomethane
Butanol
Butyl Benzyl Phthalate
Calcium mg/l
Carbofuran
Carbon Disulfide

Carbon Tetrachloride
Chemical Oxygen Demand (COD)
Chlordane
Chloride mg/l
Chlorobenzene
Chloroethane
Chloroform
Chloromethane
Chromium (hexavalent)
Chromium (total)
Chrysene
Cis-1,2-Dichloroethylene
Cobalt (total)
Copper (total)
Cyanide
DDT
Delta – BHC
Di-N-Butyl Phthalate
Di-N-Octyl Phthalate
Dibenzo (a,h) Anthracene
Dibromochloromethane
Dibromomethane
Dichlorodifluoromethane
Dieldrin
Diethyl Phthalate
Dimethyl Phthalate
Endosulfan I
Endosulfan II
Endosulfan Sulfate
Endrin

Endrin Aldehyde
Ethyl Acetate
Ethylbenzene
Ethylene Dibromide (EDB)
Fluoranthene
Fluorene
Fluoride
Heptachlor Epoxide
Heptachlor
Hexachlorobenzene
Hexachlorobutadiene
Hexachlorocyclopentadiene
Hexachloroethane
Ideno (1,2,3-cd) Pyrene
Iodomethane
Isopropylbenzene
Lead (total)
Lindane
Magnesium (total)
Manganese (total)
Mercury (total)
Methoxychlor
Methyl Chloride
Methyl Ethyl Ketone
Methylene Bromide
Methylene Chloride
Naphthalene
Nickel (total)
Nitrate-Nitrogen
Nitrobenzine

Oil. Hexane Soluble (or Equivalent)
Parathion
Pentachlorophenol
Phenanthrene
Phenols
Phosphorous
Polychlorinated Biphenyls
Potassium
Pyrene
Selenium
Silver (total)
Specific Conductance
Sodium
Styrene
Sulfate
Temperature of Leachate Sample (ºF)
tert-Butylbenzene
Tetrachlorodibenzo-p-Dioxins
Tetrachloroethylene
Tetrahydrofuran
Thallium
Tin
Toluene
Total Organic Carbon (TOC)
Total Dissolved Solids (TDS) mg/l
Total Suspended Solids (TSS) mg/l
Toxaphene
trans-1,2-Dichloroethylene
trans-1,3-Dichlorpropene
Trichloroethylene

Trichlorofluoromethane
Vinyl Acetate
Vinyl Chloride
Xylene
Zinc (total)
m-Dichlorobenzene
m-Xylene
n-Butylbenzene
n-Nitrosodimethylamine
n-Nitrosodiphenylamine
n-Nitrosodipropylamine
n-Propylbenzene
o-Chlorotoluene
o-Dichlorobenzene
o-Nitrophenol
o-Xylene
p-Chlorotoluene
p-Cresol
p-Dichlorobenzene
p-Isopropyltoluene
p-Nitrophenol
p-Xylene
sec-Butylbenzene

Note: All parameters shall be determined from unfiltered samples.

(Source: Added at 31 Ill. Reg. _____, effective _____)

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF PROPOSED AMENDMENTS

1) Heading of the Part: Illinois Home Health, Home Services, and Home Nursing Agency Code

2) Code Citation: 77 Ill. Adm. Code 245

3)

Section Numbers:	Proposed Action:
245.10	Amendment
245.20	Amendment
245.25	Amendment
245.30	Amendment
245.40	Amendment
245.50	Repeal
245.60	Amendment
245.70	Amendment
245.71	New
245.75	New
245.80	Amendment
245.90	Amendment
245.95	New
245.100	Amendment
245.110	Amendment
245.115	New
245.120	Amendment
245.130	Amendment
245.150	Amendment
245.200	New
245.205	New
245.210	New
245.212	New
245.214	New
245.220	New
245.225	New
245.240	New
245.250	New

4) Statutory Authority: Home Health, Home Services, and Home Nursing Agency Licensing Act [210 ILCS 55]

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF PROPOSED AMENDMENTS

5) A Complete Description of the Subjects and Issues Involved: The Illinois Home Health, Home Services, and Home Nursing Agency Code [77 Ill. Adm. Code 245] regulates home health agencies, including organization, staffing, services, training for home health aides, licensure, violations, and complaints. The proposed amendments will implement Public Act 94-0379, enacted by the General Assembly in 2005. PA 94-0379 changed the name of the Home Health Agency Licensing Act to the Home Health, Home Services, and Home Nursing Agency Licensing Act and required the licensure of home services agencies and home nursing agencies after September 1, 2008. The other extensive amendments in PA 94-0379 are incorporated into this rulemaking.

Section 245.10 (Purpose) is being amended to incorporate the new Sections in the Home Health, Home Services, and Home Nursing Agency Licensing Act [210 ILCS 55] (the Act) that authorize the rulemaking.

Section 245.20 (Definitions) is being amended to add new definitions from PA 94-0379 and to update some existing definitions to bring the Section in conformity with the Act.

Section 245.25 (Incorporated and Referenced Materials) is being amended to update federal regulations and State statutes and rules incorporated or referenced in Part 245.

Section 245.30 (Organization and Administration) is being amended to add a job description for "agency manager" and otherwise bring the organizational and administration structures of home health, home services, and home nursing agencies into conformity with PA 94-0379.

Section 245.40 (Staffing and Staff Responsibilities) is being amended to add a statutory definition of "home services worker" and to list the duties and responsibilities of home services workers. Other language is the Section also is being updated.

Section 245.50 (Services) is being repealed.

Section 245.60 (Annual Financial Statement) and Section 245.70 (Home Health Aide Training) are receiving minor changes to bring them into conformity with the Act.

Section 245.71 (Home Services Worker Training) is being added to set minimum requirements for the training of home services workers, including ensuring that home services workers undergo a background check and a competency evaluation, and receive eight hours of training every twelve months.

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF PROPOSED AMENDMENTS

Section 245.75 (Infection Control) is being added to require all agencies to develop and implement policies and procedures for investigating, controlling, and preventing infections.

Section 255.80 (Licensure Required) is being amended to add statutory language prohibiting anyone from opening, managing, conducting, or maintaining a home services agency or a home nursing agency after September 1, 2008, without first obtaining a license from the Department of Public Health.

Section 245.90 (License Application) is being amended to add statutory language from PA 94-0379 and otherwise bring the Section into conformity with the Act.

Section 245.95 (License Application Fee) is being added to establish licensure fees for home nursing agencies, home nursing placement agencies, home services placement agencies, and home health agencies.

Section 245.100 (Provisional License) is being amended to bring the language regarding provisional licenses into conformity with the Act. Section 245.110 (Inspections and Investigations) is receiving minor amendments to bring it into conformity with the Act.

Section 245.115 (Complaints) is being added to establish procedures for handling complaints.

Section 245.120 (Violations), Section 245.130 (Adverse Licensure Actions), and Section 245.150 (Hearings) are receiving minor amendments to update references to other State statutes and bring them into conformity with the Act.

Section 245.200 (Services – Home Health) is being added to establish the kinds of services home health agencies are expected to provide, including skilled nursing service, at least one other kind of home health service, a plan of treatment, a patient care plan, policies governing the administration of drugs and biologicals, and so on.

Section 245.205 (Services – Home Nursing Agencies) is being added to establish the kind of services expected of home nursing agencies, whether directly or through a contractual purchase of services.

Section 245.210 (Services – Home Services Agencies) is being added to establish the kind of minimal non-medical services expected of home service agencies, including acceptance of clients and a plan of service.

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF PROPOSED AMENDMENTS

Section 245.212 (Services – Home Nursing Placement Agencies) is being added to establish the minimum requirements for licensure as a home nursing placement agency.

Section 245.214 (Services – Home Services Placement Agency) is being added to establish the minimum requirements for licensure as a home services placement agency.

Section 245.220 (Client Service Contracts – Home Nursing and Home Services Agencies) is being added to require that there be a contract between home nursing or home services agencies and a client, and to outline the minimum requirements for all contracts.

Section 245.225 (Client Service Contracts – Home Nursing Placement Agency and Home Services Placement Agency) is being added to require that there be a contract between home nursing placement or home services placement agencies and a client, and to outline the minimum requirements for all contracts.

Section 245.240 (Quality Improvement Program) is being added to establish the minimum requirements for mandated quality improvement programs.

Section 245.250 (Abuse, Neglect, and Financial Exploitation Prevention and Reporting) is being added to establish minimum requirements for reporting complaints of abuse, neglect, and financial exploitation, including requirements for agencies and agency employees and volunteers.

The economic effect of this proposed rulemaking is unknown. Therefore, the Department requests any information that would assist in calculating this effect.

The Department anticipates adoption of this rulemaking approximately six to nine months after publication of the Notice in the *Illinois Register*.

6) Published studies or reports, and sources of underlying data, used to compose this rulemaking: None

7) Will this rulemaking replace any emergency rulemaking currently in effect? No

8) Does this rulemaking contain an automatic repeal date? No

9) Does this rulemaking contain incorporations by reference? Yes

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF PROPOSED AMENDMENTS

10) Are there any other proposed rulemakings pending on this Part? No

11) Statement of Statewide Policy Objectives: The rulemaking does not create a State Mandate.

12) Time, Place, and Manner in which interested persons may comment on this proposed rulemaking: Interested persons may present their comments concerning this rulemaking within 45 days after this issue of the *Illinois Register* to:

Susan Meister
Division of Legal Services
Illinois Department of Public Health
535 West Jefferson St., 5th Floor
Springfield, Illinois 62761

217/782-2043
e-mail: rules@idph.state.il.us

13) Initial Regulatory Flexibility Analysis:

A) Type of small businesses, small municipalities and not-for-profit corporations affected: home health, home services, and home nursing agencies

B) Reporting, bookkeeping or other procedures required for compliance: bookkeeping, reporting and record-keeping will be required for compliance

C) Types of professional skills necessary for compliance: nursing

14) Regulatory Agenda on which this rulemaking was summarized: January 2007

The full text of the Proposed Amendments begins on the next page:

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF PROPOSED AMENDMENTS

TITLE 77: PUBLIC HEALTH
CHAPTER I: DEPARTMENT OF PUBLIC HEALTH
SUBCHAPTER b: HOSPITALS AND AMBULATORY CARE FACILITIES

PART 245
~~ILLINOIS~~ HOME HEALTH, HOME SERVICES,
AND HOME NURSING AGENCY CODE

SUBPART A: GENERAL PROVISIONS

Section
245.10 Purpose
245.20 Definitions
245.25 Incorporated and Referenced Materials

SUBPART B: OPERATIONAL REQUIREMENTS

Section
245.30 Organization and Administration
245.40 Staffing and Staff Responsibilities
245.50 Services (Repealed)
245.55 Vaccinations
245.60 Annual Financial Statement
245.70 Home Health Aide Training
245.71 Qualifications and Requirements for Home Services Workers
245.72 Health Care Worker Background Check
245.75 Infection Control

SUBPART C: LICENSURE PROCEDURES

Section
245.80 Licensure Required
245.90 License Application
245.95 License Application Fee
245.100 Provisional License
245.110 Inspections and Investigations
245.115 Complaints
245.120 Violations
245.130 Adverse Licensure Actions

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF PROPOSED AMENDMENTS

245.140 Penalties and Fines
245.150 Hearings

SUBPART D: CLIENT/PATIENT SERVICES

245.200 Services – Home Health
245.205 Services – Home Nursing Agencies
245.210 Services – Home Services Agencies
245.212 Services – Home Nursing Placement Agency
245.214 Services – Home Services Placement Agency
245.220 Client Service Contracts – Home Nursing and Home Services Agencies
245.225 Client Service Contracts – Home Nursing Placement Agency and Home Services Placement Agency
245.240 Quality Improvement Program
245.250 Abuse, Neglect, and Financial Exploitation Prevention and Reporting

AUTHORITY: Implementing and authorized by the Home Health, Home Services, and Home Nursing Agency Licensing Act [210 ILCS 55].

SOURCE: Adopted at 2 Ill. Reg. 31, p. 77, effective August 2, 1978; emergency amendment at 3 Ill. Reg. 38, p. 314, effective September 7, 1979, for a maximum of 150 days; amended at 3 Ill. Reg. 40, p. 153, effective October 6, 1979; emergency amendment at 4 Ill. Reg. 18, p. 129, effective April 21, 1980, for a maximum of 150 days; amended at 4 Ill. Reg. 40, p. 56, effective September 23, 1980; emergency amendment at 6 Ill. Reg. 5855, effective April 28, 1982, for a maximum of 150 days; amended at 6 Ill. Reg. 11006, effective August 30, 1982; amended at 7 Ill. Reg. 13665, effective October 4, 1983; codified at 8 Ill. Reg. 16829; amended at 9 Ill. Reg. 4836, effective April 1, 1985; amended at 14 Ill. Reg. 2382, effective February 15, 1990; amended at 15 Ill. Reg. 5376, effective May 1, 1991; amended at 18 Ill. Reg. 2414, effective January 22, 1994; emergency amendments at 20 Ill. Reg. 488, effective January 1, 1996, for a maximum of 150 days; emergency expired May 29, 1996; amended at 20 Ill. Reg. 3273, effective February 15, 1996; amended at 20 Ill. Reg. 10033, effective July 15, 1996; amended at 22 Ill. Reg. 3948, effective February 13, 1998; amended at 22 Ill. Reg. 22050, effective December 10, 1998; amended at 23 Ill. Reg. 1028, effective January 15, 1999; amended at 24 Ill. Reg. 17213, effective November 1, 2000; amended at 25 Ill. Reg. 6379, effective May 1, 2001; amended at 26 Ill. Reg. 11241, effective July 15, 2002; amended at 28 Ill. Reg. 3487, effective February 9, 2004; amended at 28 Ill. Reg. 8094, effective May 26, 2004; amended at 29 Ill. Reg. 20003, effective November 28, 2005; amended at 31 Ill. Reg. 9453, effective June 25, 2007; amended at 31 Ill. Reg. _____, effective _____.

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF PROPOSED AMENDMENTS

SUBPART A: GENERAL PROVISIONS

Section 245.10 Purpose

a) This Part has been adopted in accordance with Sections 6, 6.3 and 6.7 of the Home Health, Home Services and Home Nursing Agency Licensing Act (the Act) [210 ILCS 55/6, 6.3 and 6.7]~~Section 6 of the Home Health Agency Licensing Act ("the Act") (Ill. Rev. Stat. 1989, ch. 111½, par. 2806)~~.

b) Home health agencies licensed under the Act and this Part may be eligible for participation in the federal Medicare program under the rules of the federal Centers for Medicare and Medicaid Services ~~Health Care Financing Administration~~ (42 CFR 484.1 through 484.40).

c) *Health care and support services are provided in the consumer's home by* three *basic types of agencies: home health care, home nursing care, and home support services. Each type of agency delivers a different type and scope of care or service.* (Section 1.01 of the Act)

(Source: Amended at 31 Ill. Reg. _____, effective _____)

Section 245.20 Definitions

Act – the Home Health, Home Services and Home Nursing Agency Licensing Act [210 ILCS 55].

~~Administrator – any one of the following:~~

~~a physician;~~

~~a registered nurse;~~

~~an individual with at least one year of supervisory or administrative experience in home health care or in related health provider programs; or~~

~~an individual who meets the requirements for Public Health Administrator as contained in 77 Ill. Adm. Code 600.300 of the Certified Local Health Department Code (77 Ill. Adm. Code 600) as promulgated by the Department.~~

Advocate – a person who represents the rights and interests of an individual as though they were the person's own, in order to realize the rights to which the individual is entitled, obtain needed services, and remove barriers to meeting the individual's needs.

Agency – a home health agency, home nursing agency, or home services agency, unless specifically stated otherwise. (Section 2.03a of the Act)
~~Agency – a Home Health Agency, unless otherwise designated.~~

Agency Manager – the individual designated by the governing body or the entity legally responsible for the agency, who has overall responsibility for the organization and day-to-day operation of the home services or home nursing agency.

Audiologist – a person who has received a license to practice audiology pursuant to the Illinois Speech-Language Pathology and Audiology Practice Act [225 ILCS 110].

Branch Office – a location or site from which a home health agency provides services within a portion of the total geographic area served by the parent agency. The branch office is part of the home health agency and is located sufficiently close to share administration, supervision and services in a manner that renders it unnecessary for the branch independently to meet the conditions of participation as a home health agency.

Bylaws or Equivalent – a set of rules adopted by an~~a home health~~ agency for governing the agency's operation.

Client – an individual receiving services from a home nursing agency, a home services agency, or a placement agency. This term includes the service recipient's advocate or designee.

Clinical Note – a dated, written notation by a member of the health team of a contact with a patient, containing a description of signs and symptoms, treatment and/or drug given, the patient's reaction, and any changes in physical or emotional condition.

Clinical Record – an accurate account of services provided for each patient and

maintained by a home health or home nursing ~~the~~ agency in accordance with accepted professional standards.

Companionship – services that provide fellowship, care and protection for a client who, because of advanced age or physical or mental infirmity, cannot care for his or her own needs. Services include household work related to the care of the client, such as meal preparation, bed making, washing of clothes or other similar services.

Department or IDPH *– the Department of Public Health of the State of Illinois.* (Section 2.01 of the Act)

Director – the Director of Public Health of the State of Illinois, or his or her designee. (Section 2.02 of the Act)

Discharge Summary – the written report of services rendered, goals achieved, and final disposition at the time of discharge from service of a home health or home nursing agency.

Employee Prospect – a person or persons to whom an agency expects to extend an offer of employment.

Geographic Service Area – the area from which home health agency patients are drawn. This area is to be clearly defined by readily recognizable boundaries.

Health Care Professional – a physician licensed to practice medicine in all of its branches, a podiatrist, an advanced practice nurse who has a written collaborative agreement with a collaborating physician that authorizes services under the Act, or a physician assistant who has been delegated the authority to perform services under the Act by his or her supervising physician.

Home Health Agency~~Home Health Agency~~ *– a public agency or private organization that* ~~*which*~~ *provides skilled nursing services and at least one other home health service as defined* in this Part. (Section 2.04 of the Act)

Home Health Agency Administrator – any one of the following:

a physician;

a registered nurse;

an individual with at least one year of supervisory or administrative experience in home health care or in related health provider programs; or

an individual who meets the requirements for Public Health Administrator as contained in Section 600.300 of the Certified Local Health Department Code.

Home Health Aide – a person who provides personal care and emotional comfort to assist the patient toward independent living in a safe environment. A person may not be employed as a home health aide unless he/she meets the requirements of Section 245.70 of this Part.

Home Health Services – services provided to a person at his residence according to a plan of treatment for illness or infirmity prescribed by a physician or podiatrist. *Such services include part-time and intermittent nursing services and other therapeutic services such as physical therapy, occupational therapy, speech therapy, medical social services or services provided by a home health aide.* (Section 2.05 of the Act)

Home Nursing Agency – an agency that provides services directly, or acts as a placement agency, in order to deliver skilled nursing services to persons in their personal residences. A home nursing agency provides services that would require an individual licensed under the Nursing and Advanced Practice Nursing Act *to perform. A home nursing agency does not qualify for licensure as a home health agency under* the *Act. "Home nursing agency" does not include an individually licensed nurse acting as a private contractor or a person that provides or procures temporary employment in health care facilities, as defined in the Nurse Agency Licensing Act.* (Section 2.11 of the Act)

Home Nursing Services – services that would be required to be performed by an individual licensed under the Nursing and Advanced Practice Nursing Act on a shift schedule, one-time, full-time or part-time, and/or intermittent basis.

Home Services Agency – an agency that provides services directly, or acts as a placement agency, for the purpose of placing individuals as workers providing home services for consumers primarily in their personal residences. Home services agency does not include agencies licensed under the Nurse Agency

Licensing Act, the Hospital Licensing Act, the Nursing Home Care Act, or the Assisted Living and Shared Housing Act and does not include an agency that limits its business exclusively to providing housecleaning services. Programs providing services exclusively through the Community Care Program of the Illinois Department on Aging or the Department of Human Services Office of Rehabilitation Services are not considered to be a home services agency under the Act. (Section 2.08 of the Act)

Home Services or In-Home Services or In-Home Support Services – assistance with activities of daily living, housekeeping, personal laundry, and companionship provided to an individual in his or her personal residence, which are intended to enable that individual to remain safely and comfortably in his or her own personal residence. "Home services" does not include services that would be required to be performed by an individual licensed under the Nursing and Advanced Practice Nursing Act. (Section 2.09 of the Act) Home care services are focused on providing assistance that is not medical in nature, but is based upon assisting the client in meeting the demands of living independently and maintaining a personal residence, such as companionship, cleaning, laundry, shopping, meal preparation, dressing, and bathing.

Home Services Worker or In-Home Services Worker – an individual who provides home care services to a consumer in the consumer's personal residence. (Section 2.10 of the Act) The terms homemaker and companion are commonly used to refer to this type of worker.

Licensed Practical Nurse – a person currently licensed as a licensed practical nurse under the Nursing and Advanced Practice Nursing Act ~~[225 ILCS 65]~~.

Medical Social Worker – a person who is a licensed social worker or a licensed clinical social worker under the Clinical Social Work and Social Work Practice Act ~~[225 ILCS 20]~~.

Occupational Therapist – a person who is licensed as an occupational therapist under the Illinois Occupational Therapy Practice Act ~~[225 ILCS 75]~~ and meets either or both~~one or more~~ of the following requirements:

is a graduate of an occupational therapy curriculum accredited jointly by the Council on Medical Education of the American Medical Association and the American Occupational Therapy Association, or

is eligible for the National Registration Examination of the American Occupational Therapy Association.~~, or~~

~~has two years of appropriate experience as an occupational therapist and has achieved a satisfactory grade on a proficiency examination conducted, approved or sponsored by the U.S. Public Health Service, except that such examinations of proficiency do not apply with respect to persons initially licensed by a state or seeking initial qualification as an occupational therapist after December 31, 1977.~~

Occupational Therapy Assistant – a person who is licensed as an occupational therapy assistant under the Illinois Occupational Therapy Practice Act and meets ~~one or more of~~ the ~~following~~ requirements~~:~~ ~~meets the requirements~~ for certification as an occupational therapy assistant established by the American Occupational Therapy Association.~~; or~~

~~has two years of appropriate experience as an occupational therapy assistant and has achieved a satisfactory grade on a proficiency examination conducted, approved or sponsored by the U.S. Public Health Service, except that such determinations of proficiency do not apply with respect to persons initially licensed by a state or seeking initial qualification as an occupational therapy assistant after December 31, 1977.~~

Part Time or Intermittent Care – home health services given to a patient at least once every 60 days or as frequently as a few hours a day, several times per week.

Patient – a person who is under treatment or care for illness, disease, injury or conditions appropriately responsive to home health or home nursing services to maintain health or prevent illness.

Patient Care Plan – a coordinated and combined care plan prepared by and in collaboration with each discipline providing service to the patient, to the patient's family, or to both.

Person – any individual, firm, partnership, corporation, company, association or any other legal entity. (Section 2.03 of the Act)

Personal Care Services – services that are furnished to a client in the client's personal residence to meet the client's physical, maintenance, and supportive needs, when those services are not considered skilled personal care, as described in this Section and Part, and do not require physician's orders or the supervision of a nurse.

Physical Therapist – a person who is licensed as a physical therapist under the Illinois Physical Therapy Act ~~[225 ILCS 90]~~ and who meets the qualifications for a physical therapist under the Federal Conditions of Participation for Home Health Agencies established by the Centers for Medicare and Medicaid Services ~~Health Care Financing Administration~~ (42 CFR 484.1 through 484.40).

Physical Therapist Assistant – a person who is licensed as a physical therapist assistant under the Illinois Physical Therapy Act and who meets the qualifications for a physical therapist assistant under the Federal Conditions of Participation for Home Health Agencies established by the Centers for Medicare and Medicaid Services~~Health Care Financing Administration~~ (42 CFR 484.1 through 484.40).

Physician – Any person licensed to practice medicine in all of its branches under the Medical Practice Act of 1987 ~~[225 ILCS 60]~~. For a patient who has received medical care in another state, or has moved from another state, and who has not secured the services of a physician licensed in Illinois, an individual who holds an active license to practice medicine in another state will be considered the physician for the patient during this emergency (as determined by the physician) as provided in Section 3 of the Medical Practice Act of 1987. Such an emergency may not extend more than six months in any case.

Placement Agency – any person engaged for gain or profit, regardless of the agency tax status, *in the business of securing or attempting to secure work for hire for persons seeking work or workers for employers. The term includes a private employment agency and any other entity that places a worker for private hire by a consumer in that consumer's residence for purposes of providing home services. The term does not include a person that provides or procures temporary employment in health care facilities, as defined in the Nurse Agency Licensing Act.* (Section 2.12 of the Act)

Plan of Treatment – a plan based on the patient's diagnosis and the assessment of the patient's immediate and long-range needs and resources. The plan of treatment is established in consultation with, in the case of a home health agency,

the home health services team, which includes the attending physician or podiatrist, pertinent members of the agency staff, the patient, and members of the family.

Podiatrist – a person who is licensed to practice under the Podiatric Medical Practice Act of 1987 ~~[225 ILCS 100]~~.

Professional Advisory Group – a group composed of at least one practicing physician, one registered nurse (preferably a public health nurse), and with appropriate representation from other professional disciplines that are participating in the provision of home health services. It is highly recommended that a consumer be a member of the group. At least one member of the group is neither an owner nor an employee of the home health agency.

Progress Notes – a dated, written notation by a member of the health team, summarizing facts about care and the patient's response during a given period of time.

Purchase of Services/Contractual – the provision of services through a written agreement with other providers of services.

Registered Nurse – a person who is currently licensed as a registered nurse under the Nursing and Advanced Practice Nursing Act ~~[225 ILCS 65]~~.

Skilled Nursing Services – those services that, due to their nature and scope, would require the performing individual to be licensed under the Nursing and Advanced Practice Nursing Act. These services are acts requiring the basic nursing knowledge, judgment and skills acquired by means of completion of an approved nursing education program and include, but are not limited to: assessment of healthcare needs; nursing diagnosis; planning, implementation and nursing evaluation; counseling and/or patient education; health education; the administration of medications and treatments; and the coordination and/or management of a nursing or medical plan of care.

Skilled Personal Care – personal care that may be provided only by a home health aide, as defined in this Section, or an individual who is a certified or licensed health care professional under the laws of the State of Illinois.

Social Work Assistant – a person who has a baccalaureate degree in social work,

psychology, sociology, or other field related to social work and has had at least one year of social work experience in a health care setting.~~; or has two years of appropriate experience as a social work assistant and has achieved a satisfactory grade on a proficiency examination conducted, approved or sponsored by the U.S. Public Health Service, except that such determinations of proficiency do not apply with respect to persons initially licensed by a state or seeking initial qualifications as a social work assistant after December 31, 1977.~~

Speech-Language Pathologist – a person who is licensed as a speech-language pathologist under the Illinois Speech-Language Pathology and Audiology Practice Act~~ [225 ILCS 110]~~.

Student – an individual who is enrolled in an educational institution and who is receiving training in a health-related profession.

Subdivision – a component of a multi-function health agency, such as the home care department of a hospital or the nursing division of a health department, which independently meets the federal conditions of participation for home health agencies. A subdivision that has branches is regarded as a parent agency.

Substantial Compliance~~compliance~~ or Substantially Meets~~substantially meets~~ – meeting requirements except for variance from the strict and literal performance, which results in unimportant omissions or defects given the particular circumstances involved.

Subunit – a semi-autonomous organization that~~, which~~ serves patients in a geographic area different from that of the parent agency. The subunit, by virtue of the distance between it and the agency, is judged incapable of sharing administration, supervision and services.

Summary Report – a compilation of the pertinent factors from the clinical notes and progress notes regarding a patient, which is submitted to the patient's physician or podiatrist.

Supervision – authoritative procedural guidance by a qualified person of the appropriate discipline.

(Source: Amended at 31 Ill. Reg. _____, effective _____)

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF PROPOSED AMENDMENTS

Section 245.25 Incorporated and Referenced Materials

a) The following federal regulations are incorporated by reference in this Part and apply only to Medicare certified agencies:

1) Department of Health and Human Services, Centers for Medicare and Medicaid Services~~Health Care Financing Administration~~, Medicare Program Conditions of Participation for Home Health Agencies (42 CFR 484, October 1, 2006.~~1 through 484.55), October 1, 2005.~~

2) The following Infection Control Guidelines, which may be obtained from the Department of Health and Human Services Centers for Disease Control and Prevention, Atlanta, Georgia 30333.

A) Hand Hygiene in Healthcare Settings, 2002

B) Infection Control in Healthcare Personnel, 1998

b) The following guidelines of a federal agency are incorporated by reference in this Part:

Department of Health and Human Services, Centers for Disease Control and Prevention, Morbidity and Mortality Weekly Report, General Recommendations on Immunization, February 8, 2002.

c) All incorporations by reference of federal regulations and guidelines ~~and the standards of nationally recognized organizations~~ in this Part refer to the regulations and~~,~~ guidelines~~, or standards~~ on the date specified and do not include any amendments or editions subsequent to the date specified.

d) The following State statutes are referenced in this Part:

1) Administrative Review Law [735 ILCS 5/Art. III]

2) Business Corporation Act of 1983 [805 ILCS 5]

3) Illinois Administrative Procedure Act [5 ILCS 100]

4) Nursing and Advanced Practice Nursing Act [225 ILCS 65]

5) Illinois Occupational Therapy Practice Act [225 ILCS 75]

6) Illinois Physical Therapy Act [225 ILCS 90]

7) Illinois Speech-Language Pathology and Audiology Practice Act [225 ILCS 110]

8) Local Records Act [50 ILCS 205]

9) Medical Practice Act of 1987 [225 ILCS 60]

10) Health Care Worker Background Check Act [225 ILCS 46]

11) Nurse Agency Licensing Act [225 ILCS 510]

12) Clinical Social Worker and Social Work Practice Act [225 ILCS 20]

13) Podiatric Medical Practice Act of 1987 [225 ILCS 100]

14) Assisted Living and Shared Housing Act [210 ILCS 9]

15) Code of Civil Procedure, Article VIII, Part 21 (Medical Studies) [735 ILCS 5/Art. VIII, Part 21]

e) The following State rules are referenced in this Part:

1) Department of Public Health, Certified Local Health Department Code (77 Ill. Adm. Code 600)

2) Department of Public Health, Rules of Practice and Procedure in Administrative Hearings (77 Ill. Adm. Code 100)

3) Department of Public Health, Long-Term Care Assistants and Aides Training Programs Code (77 Ill. Adm. Code 395).

4) Department of Public Health, Health Care Worker Background Check Code (77 Ill. Adm. Code 955)

5) Department of Public Health, Central Complaint Registry (77 Ill. Adm. Code 400)

(Source: Amended at 31 Ill. Reg. _____, effective _____)

SUBPART B: OPERATIONAL REQUIREMENTS

Section 245.30 Organization and Administration

a) Governing Body – All Agencies~~.~~
The ~~home health~~ agency shall have a governing body or a clearly defined body having legal authority and responsibility for the conduct of the ~~home health~~ agency. Where the governing body of a large organization is functionally remote from the operation of the ~~home health~~ agency, the Department may approve the designation of an intermediate level "governing body". For the purposes of this Section, the governing body shall:

1) Have bylaws or the equivalent, which shall be reviewed annually and be revised as needed. They shall be made available to all members of the governing body and of the professional advisory group. The bylaws or the equivalent shall specify the objectives of the agency.

~~2) Appoint members of the professional advisory group.~~

~~3) Employ a qualified administrator.~~

2~~4~~) Adopt and revise, as needed, policies and procedures for the operation and administration of the agency.

3~~5~~) Meet to review the operation of the agency.

4~~6~~) Keep minutes of all meetings.

5~~7~~) Provide and maintain an office facility adequately equipped for efficient work and that provides a safe working environment in compliance with local ordinances and fire regulations.

~~b) Professional Advisory Group~~

~~1) The professional advisory group shall assist in developing and recommending policies and procedures for administration and home health services provided by the agency. These policies and procedures shall be in accordance with the scope of services offered by the agency and based on the home health needs of the patient and the area being served. Policies and procedures shall be reviewed annually or more frequently as needed to determine their adequacy and suitability. Recommendations for any improvements are made to the Governing Body. These policies and procedures shall include but not be limited to:~~

~~A) Administration and supervision of the agency and the home health services it provides.~~

~~B) Criteria for the acceptance, non-acceptance and discharge of patients.~~

~~C) Home health services.~~

~~D) Medical supervision and plans of treatment.~~

~~E) Patient care plans.~~

~~F) Clinical records.~~

~~G) Personnel data.~~

~~H) Evaluation.~~

~~I) Coordination of services.~~

~~2) The group shall keep minutes of its meetings and meet as often as necessary to carry out its purposes.~~

b~~c~~) Administration - All Agencies

1) The ~~home health~~ agency shall have written administrative policies and procedures to ensure the provision of safe and adequate care of the patient or client.

2) The ~~home health~~ agency shall show evidence of liability insurance.

3) The agency shall develop and implement written policies for complaint resolution between the agency and its patients/clients and/or patient/client advocates in regard to services being provided to the patient/client.

~~d) Agency Supervision~~

~~1) The home health agency shall designate a person with one of the following sets of qualifications to supervise the provision of home health services:~~

~~A) A physician;~~

~~B) A registered nurse who:~~

~~i) Has completed a baccalaureate degree program approved by the National League for Nursing; and~~

~~ii) Has at least one year of nursing experience.~~

~~C) A registered nurse who does not have a baccalaureate degree, but who has at least three years of nursing experience, which meets the following requirements:~~

~~i) At least two years of such nursing experience must have been in either: a home health agency; a community health program that included care of the sick; or a generalized family-centered nursing program in a community health agency.~~

~~ii) At least two years of the three years nursing experience must have been obtained within five years prior to current employment with the home health agency.~~

~~2) The agency supervisor shall be available at all times during operating hours of the agency and participate in all activities relevant to the provision of home health services.~~

~~3) Any person employed as an agency supervisor prior to July 1, 1983, may~~

~~continue to serve in that capacity at that agency only without meeting the qualifications for agency supervisor that were in effect prior to October 1, 1983.~~

~~4) One person may hold the positions of both administrator and agency supervisor, if that person meets the requirements of both positions.~~

~~e) Supervising Nurse~~

~~1) The skilled nursing service of a home health agency shall be under the supervision of a full-time registered nurse.~~

~~2) The supervising nurse shall be responsible for:~~

~~A) The overall supervision of all registered nurses, licensed practical nurses and home health aides.~~

~~B) The assurance that the professional standards of community nursing practice are maintained by all nurses providing care.~~

~~C) Maintaining and adhering to agency procedure and patient care policy manuals.~~

~~D) Participation in the establishment of service policies and procedures.~~

~~E) Participation in the selection of nursing personnel and the evaluation of nursing personnel.~~

~~F) Coordination of patient care services.~~

~~G) Keeping and maintaining records of case assignments and case management.~~

~~H) Preparation and maintenance of scheduling of cases to be brought to the clinical record review committee.~~

~~I) The conduct of selective program evaluations to improve deficient services and the development and implementation of plans of~~

~~correction.~~

c~~f~~) Personnel Policies – All Agencies (Placement agencies must adhere to subsections (c)(2), (3) and (4))

1) Personnel policies applicable and available to all full- and part-time employees shall include, but not be limited to, the following:

A) Wage scales, fringe benefits, hours of work and leave time;~~.~~

B) Requirements for an initial health evaluation of each new employee who has contact with clients/patients, including a physical examination and any other components as specified by the governing body;~~.~~

C) Orientation to the ~~home health~~ agency and appropriate continuing education;~~.~~

D) Job descriptions for all positions utilized by the agency;~~.~~

E) Annual performance evaluation for all employees;~~.~~

F) Compliance with all applicable requirements of the Civil Rights Act of 1964;~~.~~

G) Provision for confidentiality of personnel records;~~.~~

H) Employee health policies that require employees to report health symptoms and exposure to any communicable or infectious disease and that specify conditions under which employees are to be removed from patient or client contact and conditions under which employees may resume patient/client contact; and~~.~~

I) Agency procedures related to identifying potential dangers to the health and safety of agency personnel providing services in the home and procedures for protecting agency personnel from identified dangers.

2) Prior to employing or placing any individual in a position that requires a

State professional license, the ~~home health~~ agency shall contact the Illinois Department of Financial and Professional Regulation to verify that the individual's license is active. A copy of the verification of the individual's license shall be placed in the individual's personnel file.

3) The ~~home health~~ agency shall check the status of employee or placement prospects who have direct patient/client care responsibilities with the Health Care Worker~~Nurse Aide~~ Registry prior to hiring.

4) Personnel records for all employees/placement agency registry files for placement workers shall include the name and address of the employee or placement worker, Social Security~~social security~~ number, date of birth, name and address of next of kin, evidence of qualifications (including any current licensure, registration, or certification that is required by State~~state~~ or federal law for the functions performed), and dates of employment or placement and separation from the agency and the reason for separation.

5) Home health agencies that provide other home health services under arrangement through a contractual purchase of services shall ensure that these services are provided by qualified personnel, who hold any current licensure, registration, or certification that is required by State~~state~~ or federal law for the functions performed, under the supervision of the agency.

d) Professional Advisory Group - Home Health Agencies

1) The professional advisory group shall be appointed by the governing body and shall assist in developing and recommending policies and procedures for administration and home health services provided by the agency. These policies and procedures shall be in accordance with the scope of services offered by the agency and based on the home health needs of the patient and the area being served. Policies and procedures shall be reviewed annually or more frequently as needed to determine their adequacy and suitability. Recommendations for any improvements are made to the governing body. These policies and procedures shall include, but are not limited to:

A) Administration and supervision of the home health agency and the home health services it provides;

B) Criteria for the acceptance, non-acceptance, and discharge of patients;

C) Home health services;

D) Medical supervision and plans of treatment;

E) Patient care plans;

F) Clinical records;

G) Personnel data;

H) Evaluation; and

I) Coordination of services.

2) The group shall keep minutes of its meetings and meet as often as necessary to carry out its purposes.

e) Agency Supervision – Home Health Agencies

1) The home health agency shall designate a person with one of the following sets of qualifications to supervise the provision of home health services:

A) A physician;

B) A registered nurse who:

i) Has completed a baccalaureate degree program approved by the National League for Nursing; and

ii) Has at least one year of nursing experience;

C) A registered nurse who does not have a baccalaureate degree, but who has at least three years of nursing experience that meets the following requirements:

i) At least two years of the nursing experience must have been in: a home health agency; a community health program that included care of the sick; or a generalized family-centered nursing program in a community health agency.

ii) At least two years of the three years nursing experience must have been obtained within five years prior to current employment with the home health agency.

2) The agency supervisor shall be available at all times during operating hours of the agency and participate in all activities relevant to the provision of home health services.

3) Any person employed as an agency supervisor prior to July 1, 1983, who does not meet the qualifications for agency supervisor that were in effect prior to October 1, 1983, may continue to serve in that capacity only at that agency.

4) One person may hold the positions of both administrator and agency supervisor, if that person meets the requirements of both positions.

f) Supervising Nurse – Home Health Agencies

1) The skilled nursing service of a home health agency shall be under the supervision of a full-time registered nurse.

2) The supervising nurse shall be responsible for:

A) The overall supervision of all registered nurses, licensed practical nurses, and home health aides;

B) Assuring that the professional standards of community nursing practice are maintained by all nurses providing care;

C) Maintaining and adhering to agency procedure and patient care policy manuals;

D) Participation in the establishment of service policies and procedures;

E) Participation in the selection of nursing personnel and the evaluation of nursing personnel;

F) Coordination of patient care services;

G) Keeping and maintaining records of case assignments and case management;

H) Preparation and maintenance of scheduling of cases to be brought to the clinical record review committee; and

I) The conduct of selective program evaluations to improve deficient services and the development and implementation of plans of correction.

g) Agency Manager – Home Services and Home Nursing Agencies

1) A home services agency shall designate a person to supervise the provision of services or oversee the placement of workers through the licensed home services agency.

2) A home nursing agency shall designate a person who is qualified under the laws of the State of Illinois to supervise the provision of skilled nursing care to clients or to oversee the placement of workers qualified to provide skilled nursing services to consumers through the licensed home nursing agency.

(Source: Amended at 31 Ill. Reg. _____, effective _____)

Section 245.40 Staffing and Staff Responsibilities

a) Home Health Administrator/Agency Manager. The administrator and/or agency manager shall have the following responsibilities:

1) Ensure that the agency is in compliance with all applicable federal, State and local laws.

2) Be familiar with the applicable rules of the Department and maintain them within the agency.

3) Familiarize all employees as well as providers through contractual purchase of services with the law and the rules of the Department and make copies available for their use.

4) Ensure the completion, maintenance and submission of such reports and records as required by the Department.

5) Maintain ongoing liaison with the governing body, professional advisory group, staff members and the community.

6) Maintain a current organizational chart to show lines of authority down to the patient or client level.

7) Have the authority for the management of the business affairs and the overall operation of the agency.

8) Maintain appropriate personnel records, administrative records and all policies and procedures of the agency.

9) Employ qualified personnel in accordance with job descriptions.

10) Provide orientation of new staff, regularly scheduled in-service education programs and opportunities for continuing education for the staff.

11) Designate in writing the qualified staff member to act in the absence of the administrator.

b) Home Health Aide

1) When home health aide services are offered, the services shall be under the supervision of a registered nurse in accordance with the plan of treatment. The home health aide is assigned to a particular patient by a registered nurse. Written instructions for patient care are prepared by a registered nurse or the appropriate therapist.

2) Duties of the home health aide may include:

A) The performance of simple procedures as an extension of therapeutic services.

B) Personal care, as defined in this Part.

C) Ambulation and exercise of the patient.

D) Household services essential to health care at home.

E) Assistance with medications that are ordinarily self-administered.

F) Reporting changes in the patient's/client's condition and needs to the registered nurse or the appropriate therapist.

G) Completion of appropriate records.

3) The registered nurse or appropriate therapist shall make a supervisory visit to the patient's residence at least every two weeks either when the home health aide is present to observe and assist, or when the home health aide is absent to assess relationships and determine whether goals are being met.

c) Home Services or In-Home Services Worker

1) As defined in this Part and under the Act, *Home Services or in-home services means assistance with activities of daily living , housekeeping, personal laundry, and companionship provided to an individual in his or her personal residence, which are intended to enable that individual to remain safely and comfortably in his or her own personal residence. Home Services or in home services does not include services that would be required to be performed by an individual licensed under the Nursing and Advanced Practice Nursing Act.* (Section 2.09 of the Act) Home services are focused on providing assistance that is not medical in nature, but is based upon assisting the client in meeting the demands of living independently and maintaining a personal residence, such as companionship, cleaning, laundry, shopping, meal preparation, dressing, and bathing.

2) Home Services or In-Home Services Workers will provide services in accordance with the policies and requirements of the placement or employing agency, as well as the service arrangements spelled out in the contract.

3) Duties of home services or in-home services workers may include the following:

A) General client oversight;

B) Assistance with household chores, including cooking and meal preparation, cleaning and laundry;

C) Assistance in completing activities such as shopping and appointments outside of the home;

D) Companionship;

E) Completion of appropriate records documenting service provision; and

F) Assistance with activities of daily living and personal care.

4) To delineate the types of services that can be provided by a home services worker, the following are examples of limitations where a more medical model of assistance would be needed to meet higher needs of the client.

A) Skin Care. A home services worker may perform general skin care assistance. Skin care may be performed by a home services worker only when skin is unbroken, and when any chronic skin problems are not active. The skin care provided by a home services worker must be preventative rather than therapeutic in nature, and may include the application of non-medicated lotions and solutions, or of lotions and solutions not requiring a physician's prescription. Skilled skin care must be provided by an agency licensed as a home health or home nursing services agency. Skilled skin care includes wound care, dressing changes,

application of prescription medications, skilled observation and reporting.

B) Ambulation. A home services worker may assist clients with ambulation. Clients in the process of being trained to use adaptive equipment for ambulation, such as walkers, canes or wheelchairs, require supervision by an agency licensed to provide home health or home nursing services during the period of their training. Once the prescribing individual or the health care provider responsible for the training of the client is comfortable with releasing the client to work on his or her own with the adaptive equipment, a home services worker may be assigned to assist with ambulation.

C) Bathing. A home services worker may assist clients with bathing. When a client has skilled skin care needs or skilled dressings that will need attention before, during, or after bathing, the client shall be in the care of an agency licensed as a home health agency or a home nursing agency to meet those specific needs.

D) Dressing. A home services worker may assist a client with dressing. This may include assistance with ordinary clothing and application of support stockings of the type that can be purchased without a physician's prescription. A home services worker may not assist with application of an Ace bandage and anti-embolic or other pressure stockings that can be purchased only with a physician's prescription.

E) Exercise. A home services worker may assist a client with exercise. Passive assistance with exercise that can be performed by a home services worker is limited to the encouragement of normal bodily movement, as tolerated, on the part of the client, and to encouragement with a prescribed exercise program. Passive Range of Motion may not be performed by a home services worker.

F) Feeding. A home services worker may provide assistance with feeding. Home services workers can assist clients with feeding when the client can independently swallow and be positioned upright. Assistance by a home services worker does not include

syringe, tube feedings, and intravenous nutrition. Whenever there is a high risk that the client may choke as a result of the feeding, the client shall be in the care of an agency licensed as a home health or home nursing agency to fulfill this function.

G) Hair Care. As a part of the broader set of services provided to clients who are receiving home services, home services agencies may assist clients with the maintenance and appearance of their hair. Hair care within these limitations may include shampooing with non-medicated shampoo or shampoo that does not require a physician's prescription, drying, combing and styling hair.

H) Mouth Care. A home services worker may assist in and perform mouth care. This may include denture care and basic oral hygiene, including oral suctioning for mouth care. Mouth care for clients who are unconscious shall be performed by an agency licensed as a home health agency or home nursing agency.

I) Nail Care. A home services worker may assist with nail care. This assistance may include soaking of nails, pushing back cuticles without utensils, and filing of nails. Assistance by a home services worker may not include nail trimming. Clients with a medical condition that might involve peripheral circulatory problems or loss of sensation shall be under the care of an agency licensed as a home health agency or home nursing agency to meet this need.

J) Positioning. A home services worker may assist a client with positioning when the client is able to identify to the personal care staff, either verbally, non-verbally or through others, when the position needs to be changed, only when skilled skin care, as previously described, is not required in conjunction with the positioning. Positioning may include simple alignment in a bed, wheelchair, or other furniture.

K) Shaving. A home services worker may assist a client with shaving only with an electric or a safety razor.

L) Toileting. A home services worker may assist a client to and from the bathroom; provide assistance with bed pans, urinals, and

commodes; provide pericare; or change clothing and pads of any kind used for the care of incontinence.

i) A home services worker may empty or change external urine collection devices, such as catheter bags or suprapubic catheter bags. In all cases, the insertion and removal of catheters and care of external catheters is considered skilled care and shall not be performed by a home services worker.

ii) A home services worker may empty ostomy bags and provide assistance with other client-directed ostomy care only when there is no need for skilled skin care or for observation or reporting to a nurse. A home services worker shall not perform digital stimulation, insert suppositories, or give an enema.

M) Transfers. A home services worker may assist with transfers only when the client has sufficient balance and strength to reliably stand and pivot and assist with the transfer to some extent. Adaptive and safety equipment may be used in transfers, provided that the client is fully trained in the use of the equipment and can direct the transfer step by step. Adaptive equipment may include, but is not limited to, wheel chairs, tub seats, and grab bars. Gait belts may be used as a safety device for the home services worker as long as the worker has been properly trained in their use. In general, a home services worker may not assist with transfers when the client is unable to assist with the transfer. Home services workers may assist clients in the use of a mechanical or electrical transfer device only when the following conditions are met:

i) The home services worker must have been trained in the use of the mechanical or electrical transfer device by the licensed agency;

ii) The client or client representative must be able to direct the transfer step by step; and

iii) The agency must have conducted a competency evaluation of the worker using the type of device that is available in the home.

N) Medication Reminding. A home services worker may assist a client with medication reminding only when medications have been pre-selected by the client, a family member, a nurse, or a pharmacist and are stored in containers other then the prescription bottles, such as medication minders. Medication minder containers shall be clearly marked as to day and time of dosage. Medication reminding includes: inquiries as to whether medications were taken; verbal prompting to take medications; handing the appropriately marked medication minder container to the client; and opening the appropriately marked medication minder container for the client if the client is physically unable to open the container. These limitations apply to all prescription and all over-the-counter medications. The home services worker shall immediately report to the supervisor any irregularities noted in the pre-selected medications, such as medications taken too often or not often enough, or not at the correct time as identified in the written instructions.

O) A home services worker shall not provide respiratory care. Respiratory care is skilled and includes postural drainage, cupping, adjusting oxygen flow within established parameters, nasal, endotracheal, and tracheal suctioning, and turning off or changing tanks. However, home services workers may temporarily remove and replace a cannula or mask from the client's face for the purposes of shaving or washing a client's face and may provide oral suctioning.

5) In addition to the exclusions prescribed in subsection (c)(4), home services workers shall not act in the following capacities:

A) Provide skilled personal care services as defined in Section 245.20;

B) Become or act as a Power of Attorney;

C) Be involved in any financial transactions of the client outside of contracted services. In such cases, the home services worker shall follow agency policies in regard to securing receipts for items purchased and ensuring both client and worker signatures documenting those expenditures;

D) Perform or provide medication setup for a client; and

E) Other actions specifically prohibited by agency policy.

6) Supervision of a home services worker or aide shall include the following (these provisions do not apply to placement agencies):

A) An individual who is in a supervisory capacity shall be designated and available to the worker for questions at all times.

B) On-site supervision shall take place at a minimum every 90 days or more often if the plan of service requires it.

C) Supervision does not constitute time or an activity that can be billed as a service to the client/consumer.

d~~c~~) Licensed Practical Nurse

1) The licensed practical nurse may perform selected acts in accordance with the ~~Illinois~~ Nursing and Advanced Practice Nursing Act ~~of 1987 [225 ILCS 65]~~, including the administration of treatments and medications in the care of the ill, injured, or infirm, the maintenance of health, and prevention of illness, under the direction of a registered nurse.

2) The licensed practical nurse shall report changes in the patient's condition to the registered nurse, and these reports shall be documented in the clinical notes.

3) The licensed practical nurse shall prepare clinical notes for the clinical record.

e~~d~~) Medical Social Worker. When provided, medical social services shall be given by a social worker or by a social work assistant under the supervision of a social

worker in accordance with the plan of treatment. These services shall include the following:

1) Assist the physician or podiatrist and other members of the health team in understanding significant social and emotional factors related to the patient's health problems.

2) Assess the social and emotional factors in order to estimate the patient's capacity and potential to cope with the problems of daily living.

3) Help the patient and family to understand, accept, and follow medical recommendations and provide services planned to restore the patient to the optimum social and health adjustment within the patient's capacity.

4) Assist the patient and family with personal and environmental difficulties that~~which~~ predispose toward illness or interfere with obtaining maximum benefits from medical care.

5) Utilize all available resources, such as family and community agencies, to assist the patient to resume life in the community or to live within the disability.

6) Observe, record and report social and emotional changes.

7) Prepare clinical and progress notes for the clinical record.

8) Supervision of the social work assistant shall include the following:

A) A licensed social worker must be accessible by telephone to the social work assistant at all times while the social work assistant is treating patients.

B) On-site supervision shall~~should~~ take place every four to six visits. The supervisory visits may be made either when the social work assistant is present so that the supervisor may observe and assist, or when the social work assistant is absent so that the supervisor may assess relationships and determine whether goals are being met.

C) Supervision does not constitute treatment.

D) The supervisory visit shall~~should~~ include a complete on-site assessment, an on-site review of activities with appropriate revision of treatment plan, and an assessment of the utilization of outside resources.

f~~e~~) Occupational Therapist and Occupational Therapy Assistant. When required~~provided~~, occupational therapy services shall be provided~~given~~ by an occupational therapist or by an occupational therapy assistant under the supervision of an occupational therapist in accordance with the plan of treatment. These services shall include the following:

1) Assist the physician or podiatrist in evaluating the patient's level of function by applying diagnostic and prognostic procedures.

2) Guide the patient in the use of therapeutic creative and self-care activities for the purpose of improving function.

3) Observe, record and report to the physician or podiatrist the patient's reaction to treatment and any changes in the patient's condition.

4) Instruct other health team personnel, including, when appropriate, home health aides and family members in certain phases of occupational therapy in which they may work with the patient.

5) Prepare clinical and progress notes for the clinical record.

6) Supervision of the occupational therapy assistant shall include the following:

A) A licensed occupational therapist shall~~must~~ be accessible by telephone to the occupational therapy assistant at all times while the occupational therapy assistant is treating patients.

B) On-site supervision shall~~should~~ take place every four to six visits. The supervisory visits may be made either when the occupational therapy assistant is present so that the supervisor may observe and assist, or when the occupational therapy assistant is absent so that the supervisor may assess relationships and determine whether

goals are being met.

C) Supervision does not constitute treatment.

D) The supervisory visit shall~~should~~ include a complete on-site functional assessment, an on-site review of activities with appropriate revision of treatment plan, and an assessment of the utilization of outside resources.

g~~f~~) Physical Therapist and Physical Therapist Assistant

1) When provided, physical therapy services shall be given by a physical therapist or by a physical therapist assistant under the supervision of a physical therapist in accordance with the plan of treatment. These services shall include the following:

A) Review and evaluate physician's or podiatrist's referral and patient's medical record to determine physical therapy required.

B) Plan and prepare a written treatment program based on the evaluation of available patient data.

C) Perform patient tests, measurements, and evaluations, such as range-of-motion and manual muscle tests, gait and functional analyses, and body parts measurements, and record and evaluate findings to aid in establishing or revising specifics of treatment programs.

D) Plan and administer prescribed physical therapy treatment programs for patients to restore function, relieve pain, and prevent disability following disease, injury or loss of body part.

E) Administer manual therapeutic exercises to improve or maintain muscle function, applying precise amounts of manual force and guiding patient's body parts through selective patterns and degrees of movement. Instruct, motivate and assist patient in non-manual exercises, such as active regimens, isometric and progressive resistive, and in functional activities using available equipment and assistive and supportive devices, such as crutches, walkers, canes,

orthoses and prostheses. Administer treatment involving application of physical agents, such as heat, light, cold, water and electricity. Administer traction and massage. Evaluate, fit and adjust prosthetic and orthotic devices and recommend modifications to the orthotist/prosthetist.

F) Observe, record, and report to the physician or podiatrist the patient's treatment, response and progress.

G) Instruct other health team personnel, including, when appropriate, home health aides and family members in certain phases of physical therapy with which they may work with the patient.

H) Instruct patient and family in total physical therapy program.

I) Prepare clinical and progress notes for the clinical record.

2) Supervision of the physical therapist assistant shall include the following:

A) A licensed physical therapist shall~~must~~ be accessible by telephone to the physical therapist assistant at all times while the physical therapist assistant is treating patients.

B) On-site supervision shall~~should~~ take place every four to six visits. The supervisory visits may be made either when the physical therapist assistant is present so that the supervisor may observe and assist, or when the physical therapist assistant is absent so that the supervisor may assess relationships and determine whether goals are being met.

C) Supervision does not constitute treatment.

D) The supervisory visit shall~~should~~ include a complete on-site functional assessment, an on-site review of activities with appropriate revision of treatment plan, and an assessment of the utilization of outside resources.

3) The physical therapist assistant shall:

A) Be directed by and under the supervision of a licensed physical therapist.

B) Administer the physical therapy program as established by the physical therapist.

C) Administer non-complex active and passive manual therapeutic exercises, therapeutic massage, traction, heat, light, cold, water and electrical modalities to patients with relatively stable conditions.

D) Instruct, motivate and assist patients in learning and improving functional activities such as perambulation, transfers, ambulation and activities of daily living.

E) Observe patient's progress and response to treatment, and report to the physical therapist.

F) Confer with members of the health care team for planning, modifying, and coordinating treatment programs.

hg) Registered Nurse (RN). Skilled nursing services shall be provided given by a registered nurse in accordance with the plan of treatment. These services shall include the following:

1) Be responsible Have the responsibility for the observation, assessment, nursing diagnosis, counsel, care and health teaching of the ill, injured or infirm, and the maintenance of health and prevention of illness of others.

2) Maintain a clinical record for each patient receiving care.

3) Provide progress notes to the patient's physician or podiatrist about patients under care when the patient's conditions change or there are deviations from the plan of care, or at least every 60 sixty days.

4) In the case of an RN working as a part of a home health or home nursing agency, make Make home health aide assignments, prepare written instructions for the aide, and supervise the aide in the home.

5) Direct the activities of the licensed practical nurse.

6) Administer medications and treatments as prescribed by the patient's physician or podiatrist.

7) Act as the coordinator of the health care team in order to maintain the proper linkages within a continuum of care.

i~~h~~) Speech-Language Pathologist. When required~~provided~~, speech therapy services shall be provided~~given~~ by a speech-language pathologist in accordance with the plan of treatment. These services shall include the following:

1) Assist the physician in determining and recommending appropriate speech and hearing services.

2) Evaluate the patient's speech and language abilities and establish a plan of treatment.

3) Provide rehabilitation services for speech and language disorders.

4) Record and report to the patient's physician the patient's progress in treatment and any changes in the patient's condition and plan of care.

5) Instruct other health team personnel and family members in methods of assisting the patient in improving communication skills.

6) Prepare clinical and progress notes for the clinical record.

j~~i~~) Audiologist. When required~~provided~~, audiology services shall be provided~~given~~ by an audiologist in accordance with the plan of treatment. These services shall include the following:

1) Administer diagnostic hearing tests to evaluate the patient's audiological abilities.

2) Assess the patient's need for amplification.

3) Provide rehabilitative services for hearing disorders.

4) Instruct other health team personnel and family members in methods of

assisting the patient in improving communication skills.

5) Record and report to the patient's physician the patient's response to rehabilitative intervention.

kj) Student Training Program. When an agency elects to participate with an educational institution to provide clinical experience for students as part of their health-related professional training, there shall be a written agreement between the agency and each educational institution shall. The agreement must specify the responsibilities of the agency and the educational institution. The agreement shall include, at a minimum, the following provisions:

1) The agency retains the responsibility for client care;.

2) The educational institution retains the responsibility for student education;.

3) StudentThe student and faculty performance expectations;.

4) Faculty supervision of undergraduate students in the clinic and the field;.

5) Ratio of faculty to students;.

6) Confidentiality regarding patient information;.

7) Required insurance coverage; and.

8) Provisions for joint evaluation by the agency and faculty to jointly evaluateof the students' performance and of the training program.

(Source: Amended at 31 Ill. Reg. _____, effective _____)

Section 245.50 Services (Repealed)

a) Services Provided

1) Each agency shall provide skilled nursing service and at least one other home health service on a part-time or intermittent basis. The basic skilled nursing service shall be provided directly by agency staff. Other home

~~health services may be provided by agency staff directly or through a contractual purchase of services. Additional skilled specialty nursing services and use of additional nursing staff to meet changes in caseload may be provided by contract. All services shall be provided in accordance with the orders of the patient's physician or podiatrist, under a plan of treatment established by such physician or podiatrist, and under the supervision of agency staff.~~

~~2)~~ ~~The agency shall state in writing what services will be provided directly and what services will be provided under contractual arrangements.~~

~~3)~~ ~~Services provided under contractual arrangements shall be through a written agreement that includes but is not limited to the following:~~

~~A)~~ ~~Services to be provided.~~

~~B)~~ ~~Provision for adherence to all applicable agency policies and personnel requirements, including requirements for initial health evaluations and employee health policies.~~

~~C)~~ ~~Designation of full responsibility for agency control over contracted services.~~

~~D)~~ ~~Procedures for submitting clinical and progress notes.~~

~~E)~~ ~~Charges for contracted services.~~

~~F)~~ ~~Statement of responsibility of liability and insurance coverage.~~

~~G)~~ ~~Period of time in effect.~~

~~H)~~ ~~Date and signatures of appropriate authorities.~~

~~I)~~ ~~Provision for termination.~~

~~b)~~ ~~Acceptance of Patients. Patient acceptance and discharge policies shall include but not be limited to the following:~~

~~1)~~ ~~Persons shall be accepted for health service on a part-time or intermittent~~

~~basis upon a plan of treatment established by the patient's physician or podiatrist. This plan shall be in writing within 14 days after acceptance and signed by the physician within 30 days from the start of care date.~~

~~2) Prior to acceptance, the person shall be informed of the agency's charges for the various services that it offers.~~

~~3) No person shall be refused service because of age, race, color, sex, marital status, national origin or source of payment. An agency is not required to accept a patient whose source of payment is less than the cost of the service.~~

~~4) Patients are accepted for treatment on the basis of a reasonable expectation that the patient's medical, nursing, and social needs can be met adequately by the agency in the patient's place of residence.~~

~~5) When services are to be terminated by the home health agency, the patient is to be notified three working days in advance of the date of termination, stating the reason for termination. This information shall be documented in the clinical record. When indicated, a plan shall be developed or a referral made for any continuing care.~~

~~6) Services shall not be terminated until such time as the registered nurse, the appropriate therapist, or both, in consultation with the patient's physician or podiatrist, deem it appropriate or arrangements are made for continuing care.~~

~~e) Plan of Treatment~~

~~1) Skilled nursing and other home health services shall be in accordance with a plan based on the patient's diagnosis and assessment of the patient's immediate and long-range needs and resources. The plan of treatment is established in consultation with the home health services team, which includes the patient's physician or podiatrist, pertinent members of the agency staff, the patient and members of the patient's family. The plan of treatment shall include:~~

~~A) Diagnoses.~~

~~B) Functional limitations and rehabilitation potential.~~

~~C) Expected outcomes for the patient.~~

~~D) The patient's physician's or podiatrist's regimen of:~~

~~i) Medications;~~

~~ii) Treatments;~~

~~iii) Activity;~~

~~iv) Diet;~~

~~v) Specific procedures deemed essential for the health and safety of the patient;~~

~~vi) Mental status;~~

~~vii) Frequency of visits;~~

~~viii) Equipment required;~~

~~ix) Instructions for timely discharge or referral; and~~

~~x) Assessed need for influenza and pneumococcal vaccinations.~~

~~E) The patient's physician's or podiatrist's signature and date.~~

~~2) Consultation with the patient's physician or podiatrist on any modifications in the plan of treatment deemed necessary shall be documented, and the patient's physician's or podiatrist's signature shall be obtained within 30 days after any modification of the medical plan of treatment.~~

~~3) The plan shall be reviewed by the home health services team every 62 days or more often should the patient's condition warrant.~~

~~4) An updated plan of treatment shall be given to the patient's physician or podiatrist for review, for any necessary revisions, and for signature every 62 days or more often as indicated.~~

~~d) Patient Care Plan~~

~~1) Home health services from members of the agency staff as well as those under contractual arrangements shall be given in accordance with the plan of treatment and the patient care plan. The patient care plan shall be written by appropriate members of the home health services team based upon the plan of treatment and an assessment of the patient's needs, resources, family and environment. The initial assessment is to be made by a registered nurse. Assessment by other members of the health services team shall be made on orders of the patient's physician or podiatrist or by request of a registered nurse. In those circumstances where the patient's physician has ordered only therapy services, the appropriate therapist (physical therapist or speech language pathologist) may perform the initial assessment.~~

~~2) The patient care plan shall be updated as often as the patient's condition indicates. The plan shall be maintained as a permanent part of the patient's record. The patient care plan shall indicate:~~

~~A) Patient problems.~~

~~B) Patient's goals, family's goals, service goals.~~

~~C) Service approaches to modify or eliminate problems.~~

~~D) The staff responsible for a given element of service.~~

~~E) Anticipated outcome of service approach with an estimated time frame for completion.~~

~~F) Potential for discharge from service.~~

~~e) Clinical Records. Each patient shall have a clinical record, identifiable for home health services and maintained by the agency in accordance with accepted professional standards. Clinical records shall contain:~~

~~1) Appropriate identifying information for the patient, household members and caretakers, medical history and current findings.~~

~~2) A plan of treatment signed by the patient's physician or podiatrist.~~

~~3) A patient care plan developed by the home health services team that is in accord with the patient's physician's or podiatrist's plan of treatment.~~

~~4) A medication list with dates reviewed, revised and date sent to the patient's physician or podiatrist.~~

~~5) Initial and periodic patient assessments by the registered nurse, which include documentation of the patient's functional status and eligibility for service.~~

~~6) Assessments made by other members of the home health services team.~~

~~7) Signed and dated clinical notes for each contact, which are written the day of service and incorporated into the patient's clinical record at least weekly.~~

~~8) Reports on all patient home health care conferences.~~

~~9) Reports of contacts with the patient's physician or podiatrist by patient and staff.~~

~~10) Indication of supervision of home health services by the supervising nurse, a registered nurse, or other members of the home health services team.~~

~~11) Written summary reports sent to the patient's physician or podiatrist every 62 days containing home health services provided, the patient's status, recommendations for revision of the plan of treatment and the need for continuation or termination of services noted.~~

~~12) Written and signed confirmation of the patient's physician's or podiatrist's interim verbal orders.~~

~~13) A discharge summary giving a brief review of service, patient status,~~

~~reason or reasons for discharge and plans for post discharge needs of the patient. A discharge summary may suffice as documentation to close the patient record for one-time visits and short-term or event-focused or diagnosis-focused interventions. The discharge summary need not be a separate piece of paper and may be incorporated into the routine summary reports already furnished to the physician.~~

~~14) A copy of appropriate patient transfer information, when requested, if the patient is transferred to another health facility or health agency.~~

~~15) Each agency shall have a written policy on records procedures and shall retain records for a minimum of five years beyond the last date of service provided. These procedures may include that the agency will utilize and maintain faxed copies of records from licensed professionals, rather than original records, provided that the faxed copies will be maintained on nonthermal paper and that the original records will be maintained for a period of five years by the professional who originated the records. If that professional is providing services through a contract with the agency, then the contract must include that the original records must be maintained for a period of five years by the professional.~~

~~16) Those agencies which are subject to the Local Records Act should note that *except as otherwise provided by law, no public record shall be disposed of by any officer or agency unless the written approval of the appropriate Local Records Commission is first obtained.* (Section 7 of the Local Records Act [50 ILCS 205/7])~~

~~17) Each agency shall have a written policy and procedure for the protection of confidentiality of patient records, which explains the use of records, removal of records and release of information.~~

~~f) Drugs and Biologicals. The agency shall have written policies governing the supervision and administration of drugs and biologicals, which shall include but not be limited to the following:~~

~~1) All orders for medications to be given shall be dated and signed by the patient's physician or podiatrist.~~

~~2) Drugs and treatments are administered by agency staff only as ordered by~~

~~the physician, with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per agency policy developed in consultation with a physician and after an assessment of the patient.~~

~~3) All orders for medications shall contain the name of the drug, dosage, frequency, method or site of injection and permission from the patient's physician or podiatrist if the patient, the patient's family, or both are to be taught to give medications.~~

~~4) The agency's physician or podiatrist or registered nurse shall check all medicines a patient may be taking to identify possible ineffective drug therapy or adverse reactions, significant side effects, drug allergies, and contraindicated medications and shall promptly report any problem to the patient's physician or podiatrist.~~

~~5) All verbal orders for medication or change in medication orders shall be taken by the registered nurse, written, and signed by the patient's physician or podiatrist within 30 days.~~

~~6) When any experimental drug, sera, allergenic desensitizing agent, penicillin or any other potentially hazardous drug is administered, the registered nurse administering such drugs shall have an emergency plan and any drugs and devices that may be necessary in the event of a drug reaction.~~

~~g) Evaluation. The home health agency shall have written policies and shall make an overall evaluation of the agency's total program at least once a year. This evaluation shall be made by the Professional Advisory Group (or a committee of this group), home health agency staff, consumers, or representation from professional disciplines that are participating in the provision of home health services. The evaluation shall consist of an overall policy and administrative review and a clinical record review. The evaluation shall assess the extent to which the agency's program is appropriate, adequate, effective and efficient. Results of the evaluation shall be reported to and acted upon by those responsible for the operation of the agency and maintained separately as administrative records.~~

~~h) Policy and Administrative Review. As a part of the evaluation process, the~~

~~policies and administrative practices of the agency shall be reviewed to determine the extent to which they promote patient care that is appropriate, adequate, effective and efficient. Mechanisms shall be established in writing for the collection of pertinent data to assist in evaluation. The data to be considered may include but are not limited to: number of patients receiving each service offered, number of patient visits, reasons for discharge, breakdown by diagnosis, sources of referral, number of patients not accepted with reasons and total staff days for each service offered.~~

~~i) Clinical Record Review~~

~~1) At least quarterly, members of professional disciplines representing at least the scope of the agency's programs shall review a sample of both active and closed clinical records to assure that established policies are followed in providing services (direct, as well as those under contractual arrangement). This review shall include, but not be limited to:~~

~~A) Whether the patient care plan was directly related to the stated diagnosis and plan of treatment;~~

~~B) Whether the frequency of visits was consistent with the plan of treatment;~~

~~C) Whether the services could have been provided in a shorter span of time.~~

~~2) Clinical records shall be reviewed continually for each 62 day period that a patient received home health services to determine the adequacy of the plan of treatment and the appropriateness of continuing home health care.~~

(Source: Repealed at 31 Ill. Reg. _____, effective _____)

Section 245.60 Annual Financial Statement – Home Health Agencies

a) *Each* home health agency *licensee shall file annually an attested financial statement on a form prescribed, prepared and furnished by the Department in conjunction with the Illinois Department of Healthcare and Family Services~~Public Aid~~. The application shall contain such information as may be required by the Department and the Illinois Department of Healthcare and*

Family Services~~Public Aid~~ for the proper administration of the Act and this Part. *An audited financial statement may be required of a particular facility, if the Director determines that additional information is needed.* (Section 11(a) of the Act)

b) *No public funds shall be expended for the services of a home health agency which has failed to file the financial statement required by this Section*. (Section 11(b) of the Act)

c) *No other State~~state~~ agency may require submission of financial data except as expressly authorized by law or as necessary to meet requirements of federal law or regulation.* (Section 11(d) of the Act)

d) *Information obtained under this Section shall be made available, upon request, by the Department only to any other State agency or legislative commission to which such information is necessary for investigations or to execute the intent of State~~state~~ or federal law or regulation.* (Section 11(d) of the Act)

(Source: Amended at 31 Ill. Reg. _____, effective _____)

Section 245.70 Home Health Aide Training

a) Each home health agency shall ensure that all persons employed as home health aides or under any other title, whose duties are to assist with the personal, nursing or medical care of the patients, and who are not otherwise licensed, certified or registered in accordance with Illinois law to render such care, comply with one of the following conditions:

1) Is approved on the Department's Health Care Worker~~Nurse Aide~~ Registry. "Approved" means that the home health aide has met the training or equivalency requirements of this Section and does not have a disqualifying background check without a waiver (see Section 245.72);

2) Meets training requirements by completion of a training program approved under the Long-Term Care Assistants and Aides Training Programs Code (see 77 Ill. Adm. Code 395); or

3) Meets equivalencies established in subsection (b) of this Section.

b) Equivalency may be established by any one of the following:

1) Documentation of current registration from another state.

2) Documentation of successful completion of a nursing arts course, which included at least 40 hours of supervised clinical experience, in an accredited nurse training program as evidenced by diploma, certificate or other written verification from the school, and successful completion of the written portion of the Department-established nursing assistant competency test.

3) Documentation of successful completion of a United States military training program that includes the content of the Basic Nursing Assistant Training Program (see 77 Ill. Adm. Code 395), as evidenced by a diploma, certification DD-214, or other written verification, and successful completion of the written portion of the Department-established nursing assistant competency evaluation.

4) Documentation of completion of a nursing program in a foreign country, including the following, and successful completion of the written portion of the Department-established competency test:

A) A copy of the license, diploma, registration or other proof of completion of the program;

B) A copy of the Social Security card; and

C) Visa or proof of citizenship.

c) Requests to establish equivalency shall be submitted to the Department with accompanying documentation.

d) The home health agency is responsible for assuring that the individuals who furnish home health aide services on its behalf are competent to carry out assigned tasks in the patient's place of residence. The competency evaluation conducted by a registered nurse in the home health agency shall address each of the following subjects:

1) Communication skills;

2) Observation, reporting, and documentation of patient status and the care or service furnished;

3) Reading and recording temperature, pulse, and respiration;

4) Basic infection control procedures;

5) Basic elements of body functioning and changes in body function that must be reported to an aide's supervisor;

6) Maintenance of a clean, safe and healthy environment;

7) Recognizing emergencies and knowledge of emergency procedures;

8) The physical, emotional and developmental needs of and ways to work with the populations served by the home health agency, including the need for respect for the patient, his or her privacy, and his or her property;

9) Appropriate and safe techniques in personal hygiene and grooming that include:

A) Bed bath;

B) Sponge, tub or shower bath;

C) Shampoo - sink, tub, or bed;

D) Nail and skin care;

E) Oral hygiene; and

F) Toileting and elimination;

10) Safe transfer techniques and ambulation;

11) Normal range of motion and positioning;

12) Adequate nutrition and fluid intake; and

13) Any other task that the agency may choose to have the home health aide perform.

e) A home health agency shall not employ an individual as a home health aide unless the Agency has inquired of the Department as to information in the Health Care Worker~~Nurse Aide~~ Registry concerning findings of abuse, neglect~~,~~ or misappropriation of property.

(Source: Amended at 31 Ill. Reg. _____, effective _____)

Section 245.71 Qualifications and Requirements for Home Services Workers

a) Each agency shall ensure and maintain documentation in the employee file that all persons employed or providing services as an in-home services worker, and who are not otherwise licensed, certified or registered in accordance with Illinois law to render such care, comply with the following conditions:

1) Does not have a disqualifying background check under the requirements of the Health Care Worker Background Check Act without a waiver;

2) Has a copy of the Social Security card; and

3) Has visa or proof of citizenship in compliance with federal requirements for employment.

b) Each agency shall provide a minimum of eight hours of training for each home services worker prior to his or her first assignment. The training shall include all of the items noted in subsection (c) of this Section.

c) The agency is responsible for assuring that the individuals who furnish home services on its behalf are competent to carry out assigned tasks in the client's place of residence. There shall be proof of a competency evaluation conducted by the agency. The competency evaluation shall address each of the following subjects:

1) The employee's job responsibilities and limitations;

2) Communication skills in areas such as with persons who are hard of hearing, have dementia, or have other special needs;

3) Observation, reporting and documentation of client status and the service furnished, including changes in functional ability and mental status demonstrated by the client;

4) Performance of personal care tasks for clients, including: bathing; skin care; hair care; nail care; mouth care; shaving; dressing; feeding; assistance with ambulation; exercise and transfers; positioning; bladder and bowel care; and medication reminding;

5) Performance of ability to assist in the use of specific adaptive equipment, such as a mechanical lifting device, if the worker will be working with clients who use the device;

6) Basic hygiene and basic infection control practices;

7) Maintenance of a clean, safe and healthy environment;

8) Basic personal and environmental safety precautions;

9) Recognizing emergencies and knowledge of emergency procedures, including basic first aid and implementation of a client's emergency preparedness plan;

10) Confidentiality of client personal, financial and health information;

11) Behaviors that would constitute abuse or neglect and the legal prohibitions against such behaviors, as well as knowledge and understanding of abuse and neglect prevention and reporting requirements; and

12) Any other task that the agency may choose to have the worker perform.

d) All home services staff shall complete a minimum of eight hours of training, which can include self-study courses with demonstration of learned concepts that are applicable to the employee's responsibilities, every 12 months after the starting date of employment. Training shall include:

1) Promoting client dignity, independence, self-determination, privacy, choice and rights;

2) Disaster procedures;

3) Hygiene and infection control; and

4) Abuse and neglect prevention and reporting requirements.

e) All training shall be documented with the date of the training; starting and ending times; instructors and their qualifications; short description of content; and staff member's signature.

(Source: Added at 31 Ill. Reg. _____, effective _____)

Section 245.75 Infection Control

a) Each agency shall develop and implement policies and procedures for investigating, controlling and preventing infections.

b) Each agency shall adhere, at a minimum and as appropriate, to the guidelines of the Center for Infectious Diseases, Centers for Disease Control and Prevention, United States Public Health Service, Department of Health and Human Services, as incorporated in Section 245.25.

(Source: Added at 31 Ill. Reg. _____, effective _____)

SUBPART C: LICENSURE PROCEDURES

Section 245.80 Licensure Required

a) *No person shall open, manage, conduct or maintain a home health agency without a license issued by the Department.* (Section 3 of the Act)

b) *On and after September 1, 2008, no person shall open, manage, conduct, or maintain a home services agency, or advertise himself or herself as a home services agency or as offering services that would be included in the definition of home services or a home services agency, without a license issued by the Department.* (Section 3.3 of the Act)

c) *On and after September 1, 2008, no person shall open, manage, conduct, or maintain a home nursing agency, or advertise himself or herself as a home nursing agency or as offering services that would be included in the definition of a home nursing agency, without a license issued by the Department.* (Section 3.7 of the Act)

d~~b~~) License Nontransferable

1) Each license shall be issued only for the specific~~home health~~ agency named in the application and shall not be transferred or assigned to any other person, agency or corporation.

2) Sale, assignment, lease or other transfer, voluntary or involuntary, shall require relicensure by the new owner ~~or person in interest~~ prior to maintaining, operating or conducting an~~a home health~~ agency.

3) In the case of agencies operating under a franchise arrangement, each unique business entity shall obtain and maintain a distinct license and shall not share licensure based on franchised name status.

e~~c~~) Each license shall be for a term of one year and shall expire one year from the date of issuance. However, initial licenses shall expire one year from the end of the month in which the initial license was issued.

~~d)~~ ~~Subunits. A separate license for the operation of a home health agency is required for each home health agency subunit. A separate license application and fee must be submitted for each home health agency subunit.~~

f~~e~~) Out-of-State Agencies. A license is required for any ~~home health~~ agency providing care in Illinois, or functioning in a capacity of matching workers with clients or consumers for home nursing or home service care, including internet matching services where the parent agency is domiciled in a state other than Illinois. In such cases, the following conditions shall~~must~~ be met:

1) The licensee shall~~must~~ be registered to do business in Illinois under the Business Corporation Act of 1938 [805 ILCS 5]~~(Ill. Rev. Stat.. 1989, ch. 32, par. 1.01 et seq.)~~ or otherwise authorized to do business in Illinois.

2) The licensee shall~~must~~ have an office in Illinois.

3) All professional care supervisory and staff personnel caring for patients or clients residing in Illinois shall~~, will~~ be subject to any licensure, certification~~,~~ or registration that~~which~~ is required to perform the respective service in Illinois, and shall be so licensed, certified~~,~~ or registered.

g~~f~~) The licensee shall notify the Department in writing not less than 30 days prior to closing the ~~home health~~ agency.

h~~g~~) *Any ~~home health~~ agency conducted by and for the adherents of any well recognized church or religious denomination for the purpose of providing services for the care or treatment of the sick who depend upon prayer or spiritual means for healing in the practice of the religion of such church or religious denomination* is not subject to licensure. (Section 13 of the Act)

i) Subunits. A separate license for the operation of a home health agency is required for each home health agency subunit. A separate license application and fee shall be submitted for each home health agency subunit.

(Source: Amended at 31 Ill. Reg. _____, effective _____)

Section 245.90 License Application

a) Initial Application – All Agencies

1) Any person who desires to obtain a license to operate a home health, home nursing, home services, home nursing placement, or home service placement agency shall file a licensure application with the Department ~~a licensure application~~. Any person in interest, different from the licensee, who desires to conduct, maintain, or operate a home health, home nursing, home services, home nursing placement or home services placement agency shall also file an application for licensure with the Department.

2) Each initial application for licensure shall be on forms provided by the Department, and shall contain the following information:

A) *Name, address, and location of the agency;~~.~~*

B) *Organization and governing structure of the agency*;~~.~~

C) A description of the services to be provided;~~.~~

D) A list of the staff of the agency or a list of placement agency registry, including any applicable licensure, registration, or certification and any other *qualifications of the staff* of the agency;~~.~~

E) *Sources of financing of services* and any other sources of income of the agency;~~.~~

F) A description or map of the geographic *service area* in which services are provided by the agency;~~.~~

G) *Charges for services* by types of services provided by the agency; and~~.~~

H) For home health agencies, copies~~Copies~~ of any *affiliation agreements with other health care providers*. (Section 5(a) of the Act)

b) Renewal Application – All Agencies

1) Each licensee shall file a renewal application with the Department not less than 60 days, nor more than 90 days, prior to the expiration date of the licensee's current license.

2) Each renewal application shall be on forms provided by the Department and shall contain the information specified in subsection (a)(2) of this Section.

c) Renewal Application – Home Health Agencies
Applications for renewal of home health agency licenses shall additionally contain~~Each renewal application shall also include~~ the following information:

1~~A~~) *Patient load* data for the preceding year, including the number of patients discharged, the total number of patients who received services, the number of patients over 65 years of age who received services, and the number of patients being served at the end of the year; and~~.~~

2~~B~~) *Agency utilization* data, including the number of patients receiving specific types of services and the number of visits by types of services provided. (Section 5(a) of the Act)

d) *An entity that meets the requirements for licensure* under the Act and this Part *may obtain licensure singly or in any combination for the categories authorized under* the *Act* and this Part. (Section 4(d) of the Act)

e) *One application* for licensure shall *be used even if a combination of licenses authorized under the Act* and this Part *is sought. Applicants for multiple licenses shall pay the higher of the licensure fees applicable.* (Section 4(d) of the Act) The licensure fee under the multiple category shall not exceed $1500 annually.

~~c) Each initial and renewal application shall be accompanied by a *license fee of $25.* The fee is not refundable. (Section 4(c) of the Act)~~

f~~d~~) The Department will review each application. The Department will approve the application and issue an initial or renewal license to the applicant for operation of an~~a home health~~ agency~~,~~ when it finds that the applicant meets all of the *requirements of the Act and the standards established by the Department* in this Part. The Department may also issue a provisional license, as provided in Section 4 of the Act and Section 245.100 of this Part, or deny an application, as provided in Sections~~Section~~ 8 and 9 of the Act and Section 245.130 of this Part. (Section 4(c) of the Act)

(Source: Amended at 31 Ill. Reg. _____, effective _____)

Section 245.95 License Application Fee

a) *Applicants for multiple licenses under this system shall pay the higher of the licensure fees applicable.* (Section 4(d) of the Act)

b) A home nursing agency or a home service agency shall pay a licensure fee not to exceed $1500. The fee is not refundable.

c) A home nursing placement agency or home services placement agency shall pay a licensure fee not to exceed $500. The fee is not refundable.

d) Home Health Agencies. For a single home health agency license only, each initial and renewal application shall be accompanied by a *license fee of $25*. (Section 4(c) of the Act) The fee is not refundable.

(Source: Added at 31 Ill. Reg. _____, effective _____)

Section 245.100 Provisional License

a) Provisional License for New Agencies

1) If the Department is unable to determine that the agency complies with the requirements of the Act and this Part from the information provided in the application, the Department may conduct an on-site survey. The Department shall issue a provisional license to an applicant for licensure when the applicant appears to comply with the requirements of the Act and this Part, and either of the following conditions exists:

A) *The applicant for licensure has not previously been licensed.*

B) *The agency is not in operation at the time of the application*. (Section 4(a) of the Act).

2) *Within 30 days prior to the expiration of the provisional license, the Department shall inspect the agency. If the Department finds that the agency substantially meets the requirements of the Act* and this Part, *it shall issue a license.* This license shall expire one year from the end of the month in which the provisional license was first issued. The initial license fee shall be applied to this license. (Section 4(a) of the Act)

b) Provisional License for Operating Agencies

1) The Department shall issue a provisional license to an agency when it finds that all of the following conditions exist:

A) *The agency does not substantially comply with all of the requirements of the Act* and this Part.

B) The violations of the requirements of the Act and this Part are not serious enough to support adverse licensure action as provided

under Sections 8 and 9 of the Act and Section 245.130 of this Part.

C) *The health, ~~and~~ safety and well-being of the* patients and/or *clients~~patients~~ of the agency will be protected during the period for which~~of~~ the provisional license is issued*. (Section 4(b)(1) of the Act)

2) *When a provisional license is issued* to an operating agency, the Department shall notify the agency of the issuance of the provisional license. The notice to the agency shall include the following information:

A) A description of the *manner in which the agency fails to substantially comply with all of the requirements of the Act* and this Part.

B) A description of the *corrections which must be made by the ~~home health~~ agency to substantially comply with all of the requirements of the Act* and this Part.

C) A specific *time within which the necessary corrections shall be completed* by the agency. (Section 4(b)(2) of the Act)

c) *A provisional license is valid for 120 days unless sooner suspended or revoked in accordance with Section 9 of the Act* and Section 245.130 of this Part. *A provisional license will be renewed for an additional 120 days when the Department finds* that all of the following conditions exist:

1) *The agency does not substantially meet all of the requirements of the Act* and this Part.

2) *The agency has made significant progress toward correcting deficiencies and bringing the agency into full compliance with the requirements of the Act* and this Part.

3) *The health, ~~and~~ safety and well-being of the* patients and/or *clients~~patients~~ of the agency will be protected during the period for which ~~of~~ the ~~extension of the~~ provisional license* is extended. (Section 4 of the Act)

(Source: Amended at 31 Ill. Reg. _____, effective _____)

Section 245.110 Inspections and Investigations

a) *The Department will conduct such investigations and inspections* of licensed agencies and of persons suspected of operating an agency without a license *as it deems necessary to assess compliance with the Act* and this Part. ~~The Department will conduct an investigation or inspection based on complaints received by the Department when it finds that the complaint alleges a violation of the Act or this Part and that a reasonable basis exists for the complaint.~~ (Section 9.01 of the Act)

b) Agencies shall facilitate any necessary visits by the Department's staff to patients or clients in their homes during the Department's investigations or inspections. The Department will obtain *consent from the patient or client* prior to conducting *direct observation of patient care or the provision of home services in the home during an investigation or inspection*. (Section 9.01 of the Act)

c) *Agencies shall make available to the Department all books, records, policies and procedures, or any other materials requested during the course of an investigation or inspection*. (Section 9.01 of the Act)

(Source: Amended at 31 Ill. Reg. _____, effective _____)

Section 245.115 Complaints

a) Complaints in regard to agencies licensed under the Act and this Part may be submitted either in writing, by telephone or by other electronic means to the IDPH Central Complaint Registry.

b) The Department will conduct an investigation of all complaints received. An appropriate investigation may include but is not limited to record reviews and/or telephone interviews, on-site surveys or a combination of methods.

(Source: Added at 31 Ill. Reg. _____, effective _____)

Section 245.120 Violations

a) Notice of Violation

1) *When the Department determines that an~~a home health~~ agency is in*

violation of the Act or this Part, *a notice of violation shall be served on the licensee.* The notice shall be served on the licensee personally or by certified mail. (Section 9.02 of the Act)

2) *Each notice of violation shall be in writing* and shall include:

A) A description of the *nature of the violation.*

B) Citation of the *statutory provision or rule alleged to have been violated.*

C) A statement that the agency must submit a *plan of correction as provided under Section 9.03* of the Act and subsection (b) of this Section.

D) A description of additional *action the Department may take under the Act, including adverse licensure action under Section 9* of the Act and Section 245.130 of this Part *or assessment of a penalty under Section 9.04* of the Act and Section 245.140 of this Part.

E) A statement that *the licensee has a right to a hearing* to contest the violation, as provided in *Section 10* of the Act and Section 245.150 of this Part, and a description of the procedure for requesting a hearing. (Section 9.02 of the Act)

b) Plan of Correction

1) In response to the receipt of a notice of violation, *the agency shall file with the Department a written plan of correction. Each plan of correction is subject to the approval of the Department* and shall comply with the following requirements:

A) Be filed with the Department *within 10 days after~~of~~ the agency's receipt of the notice of violation.*

B) *State with particularity the method by which the agency intends to correct each violation* specified in the notice of violation.

C) *Contain a stated date by which each violation will be corrected.*

(Section 9.03 of the Act)

2) The Department will review each plan of correction. If the Department finds that the plan of correction fails to comply with the requirements in subsection (b)(1) of this Section, the Department will *reject the plan of correction* and *notify the licensee of the rejection and the reason for the rejection*. (Section 9.03 of the Act)

3) *The agency shall have 10 days after the receipt of a notice of rejection in which to submit a modified plan of correction*. The Department shall review each modified plan of correction. (Section 9.03 of the Act)

4) The Department shall *reject a modified plan* and impose a plan of correction, which the *agency shall follow*, in any of the following conditions:

A) *The modified plan is not submitted on time.*

B) The modified plan fails to resolve the reasons for the rejection of the plan of correction.

C) The modified plan fails to *state with particularity the method by which the agency intends to correct each violation* specified in the notice of violation.

D) The modified plan fails to *contain a stated date by which each violation will be corrected.* (Section 9.03 of the Act)

c) Hearing to Contest Violations

1) An agency may *contest any Department action under this Section by sending a written request for a hearing to the Department within 10 days after~~of~~ the receipt of the notice of the action being contested*, as provided in Section 10 of the Act and Section 245.150 of this Part. (Section 9.03(c) of the Act)

2) *Whenever possible, all action of the Department under this Section arising out of a violation shall be contested and determined at a single hearing.* (Section 9.03(c) of the Act)

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF PROPOSED AMENDMENTS

(Source: Amended at 31 Ill. Reg. _____, effective _____)

Section 245.130 Adverse Licensure Actions

a) Adverse licensure actions include the denial of an initial license application, denial of an application for license renewal, revocation of a license, suspension of a license, and the imposition of a penalty or fine.

b) Adverse licensure action shall be considered by the Department under the following conditions:

1) Failure of the agency to meet the standards prescribed by the Department in this Part. ~~(Section 8(a) of the Act)~~

2) *Satisfactory evidence that the moral character of the applicant or supervisor of the agency is not reputable. In determining moral character, the Department may take into consideration any convictions of the applicant or supervisor* for criminal offenses, *but such convictions shall not operate as a bar to licensing.* (Section 8(b) of the Act)

3) *Lack of personnel qualified by training and experience to properly perform the function of an~~a home health~~ agency*. This determination shall be based on the personnel requirements established in this Part. (Section 8(c) of the Act)

4) *Insufficient financial or other resources to operate and conduct a home health, home services or home nursing agency in accordance with the requirements of the Act and* this Part. (Section 8(d) of the Act)

5) *Refusal to make books, records, policies and procedures, or any other materials requested during the course of an investigation or inspection available to the Department.* (Section 9.01 of the Act)

6) *Violation of any provision of the Act* or this Part. (Section 9(a) of the Act)

7) Conduct or practice found by the Department to be detrimental to the health, safety or welfare of a patient or client.

c) In determining whether to take adverse licensure action, the Department shall consider the following factors:

1) *The gravity of the violation, including the probability that death or serious physical or mental harm to a patient or client will result or has resulted and the severity of the actual or potential harm.*

2) *The extent to which the provisions of the Act* or this Part *were violated.*

3) *The reasonable diligence exercised by the licensee and any efforts by the licensee to correct the violations.*

4) *Any previous violations committed by the licensee.*

5) *The financial benefit to the agency of committing or continuing the violation.* (Section 9.04(c) of the Act)

d) The Department shall deny an application for license renewal when the licensee *refuses to make payment at the time of the application for renewal of the license* for penalties or fines that~~which~~ have been imposed and added to the license fee. (Section 10.01(c) of the Act)

e) The Director will order an emergency suspension of a license~~,~~ when the Director finds that continued operation of the agency poses an immediate and serious danger to the public health, safety~~,~~ or welfare. The suspension shall take effect upon the issuance of an order of emergency suspension by the Director and shall remain in effect during any administrative proceeding contesting the action. Promptly following any emergency suspension of a license, the Department shall take action to revoke the license.

f) Notice of Adverse Licensure Action

1) *The Department shall notify the applicant or licensee* in writing *before~~in writing, prior to~~ denying an application refusing to renew a license, or revoking a license.* (Section 10(a) of the Act)

2) *The notice shall be served on the applicant or licensee either by personal service or by registered mail.* The notice shall contain the following information:

A) A description of the *particular reasons for the proposed action*, including citations of the specific provisions of the Act and this Part under which the proposed action is being taken.

B) The date, not less than 15 days from the date of the mailing or service of the notice, on which the action will take effect, unless appealed by the applicant or licensee.

C) A description of the manner in which the applicant or licensee may appeal the proposed action and the right of the applicant or licensee to a hearing under Section 10 of the Act and Section 245.150 of this Part. (Section 10(b) of the Act)

(Source: Amended at 31 Ill. Reg. _____, effective _____)

Section 245.150 Hearings

a) Applicants for an~~a home health~~ agency license and licensees may appeal certain actions of the Department under the Act and this Part. Following receipt of an appeal or a request for a hearing from an applicant or licensee, the Department shall conduct a hearing to review the contested action.

b) Hearings conducted pursuant to the Act and this Part shall be conducted in accordance with the following:

1) Section 10 of the Act.

2) The Illinois Administrative Procedure Act ~~(Ill. Rev. Stat. 1991, ch. 127, par. 1001 et seq.)~~.

3) The rules of the Department titled ~~entitled "~~Rules of Practice and Procedure in Administrative Hearings~~" (77 Ill. Adm. Code 100)~~.

c) Applicants and licensees have a right to administrative review of actions and decisions of the Department by the courts under the Administrative Review Law ~~(Ill. Rev. Stat. 1989, ch. 110, par. 3-101 et seq.)~~.

(Source: Amended at 31 Ill. Reg. _____, effective _____)

SUBPART D: CLIENT/PATIENT SERVICES

Section 245.200 Services – Home Health

a) Each home health agency shall provide skilled nursing service and at least one other home health service on a part-time or intermittent basis. The agency staff shall directly provide basic skilled nursing service. The agency staff may provide other home health services directly or through a contractual purchase of services. Additional skilled specialty nursing services and use of additional nursing staff to meet changes in caseload may be provided by contract. All services shall be provided in accordance with the orders of the patient's physician or podiatrist, under a plan of treatment established by such physician or podiatrist, and under the supervision of agency staff.

b) The agency shall state in writing what services will be provided directly and what services will be provided under contractual arrangements.

c) Services provided under contractual arrangements shall be through a written agreement that includes, but is not limited to, the following:

1) Services to be provided;

2) Provision for adherence to all applicable agency policies and personnel requirements, including requirements for initial health evaluations and employee health policies;

3) Designation of full responsibility for agency control over contracted services;

4) Procedures for submitting clinical and progress notes;

5) Charges for contracted services;

6) Statement of responsibility of liability and insurance coverage;

7) Period of time in effect;

8) Date and signatures of appropriate authorities; and

9) Provision for termination of services.

d) Acceptance of Patients. Patient acceptance and discharge policies shall include, but not be limited to, the following:

1) Persons shall be accepted for health services on a part-time or intermittent basis in accordance with a plan of treatment established by the patient's physician or podiatrist. This plan shall be promulgated in writing within 14 days after acceptance and signed by the physician within 30 days after the start of the care date.

2) Prior to acceptance of a patient, the agency shall inform the person of the agency's charges for the various services that it offers.

3) No person shall be refused service because of age, race, color, sex, marital status, national origin or source of payment. An agency is not required to accept a patient whose source of payment is less than the cost of services.

4) Patients are accepted for treatment on the basis of a reasonable expectation that the patient's medical, nursing and social needs can be met adequately by the agency in the patient's place of residence.

5) When services are to be terminated by the home health agency, the patient is to be notified three working days in advance of the date of termination, stating the reason for termination. This information shall be documented in the clinical record. When indicated, a plan shall be developed or a referral made for any continuing care.

6) Services shall not be terminated until such time as the registered nurse, or the appropriate therapist, or both, in consultation with the patient's physician or podiatrist, deem it appropriate or arrangements are made for continuing care.

e) Plan of Treatment
Skilled nursing and other home health services shall be in accordance with a plan based on the patient's diagnosis and assessment of the patient's immediate and long-range needs and resources. The plan of treatment is established in consultation with the home health services team, which includes the patient's

physician or podiatrist, pertinent members of the agency staff, the patient, and members of the patient's family. The plan of treatment shall include:

1) Diagnoses;

2) Functional limitations and rehabilitation potential;

3) Expected outcomes for the patient;

4) The patient's physician's or podiatrist's regimen of:

A) Medications;

B) Treatments;

C) Activity;

D) Diet;

E) Specific procedures deemed essential for the health and safety of the patient;

F) Mental status;

G) Frequency of visits;

H) Equipment required;

I) Instructions for timely discharge or referral; and

J) Assessed need for influenza and pneumococcal vaccination;

5) The patient's physician's or podiatrist's signature and date.

f) Consultation with the patient's physician or podiatrist on any modifications in the plan of treatment deemed necessary shall be documented, and the patient's physician's or podiatrist's signature shall be obtained within 30 days after any modification of the medical plan of treatment.

1) The home health services team shall review the plan every 62 days, or more often if the patient's condition warrants.

2) An updated plan of treatment shall be given to the patient's physician or podiatrist for review, for any necessary revisions, and for signature every 62 days, or more often as indicated.

g) Patient Care Plan

1) Home health services from members of the agency staff, as well as those under contractual arrangements, shall be provided in accordance with the plan of treatment and the patient care plan. The patient care plan shall be written by appropriate members of the home health services team based upon the plan of treatment and an assessment of the patient's needs, resources, family and environment. The initial assessment is to be made by a registered nurse. Assessment by other members of the health services team shall be made on orders of the patient's physician or podiatrist or by request of a registered nurse. In those circumstances in which the patient's physician has ordered only therapy services, the appropriate therapist (physical therapist, speech-language pathologist or occupational therapist) may perform the initial assessment.

2) The patient care plan shall be updated as often as the patient's condition indicates. The plan shall be maintained as a permanent part of the patient's record. The patient care plan shall indicate:

A) Patient problems;

B) Patient's goals, family's goals, and service goals;

C) Service approaches to modify or eliminate problems;

D) The staff responsible for each element of service;

E) Anticipated outcome of service approach with an estimated time frame for completion; and

F) Potential for discharge from service.

h) Clinical Records

1) Each patient shall have a clinical record, identifiable for home health services and maintained by the agency in accordance with accepted professional standards. Clinical records shall contain:

A) Appropriate identifying information for the patient, household members and caretakers, medical history, and current findings.

B) A plan of treatment signed by the patient's physician or podiatrist.

C) A patient care plan developed by the home health services team in accordance with the patient's physician's or podiatrist's plan of treatment.

D) A noted medication list with dates reviewed and revised and date sent to the patient's physician or podiatrist.

E) Initial and periodic patient assessments by the registered nurse that include documentation of the patient's functional status and eligibility for service.

F) Assessments made by other members of the home health services team.

G) Signed and dated clinical notes for each contact that are written the day of service and incorporated into the patient's clinical record at least weekly.

H) Reports on all patient home health care conferences.

I) Reports of contacts with the patient's physician or podiatrist by patient and staff.

J) Indication of supervision of home health services by the supervising nurse, a registered nurse, or other members of the home health services team.

K) Written summary reports sent to the patient's physician or podiatrist every 62 days, containing home health services provided, the patient's status, recommendations for revision of the plan of treatment, and the need for continuation or termination of services.

L) Written and signed confirmation of the patient's physician's or podiatrist's interim verbal orders.

M) A discharge summary giving a brief review of service, patient status, reason for discharge, and plans for post-discharge needs of the patient. A discharge summary may suffice as documentation to close the patient record for one-time visits and short-term or event-focused or diagnoses-focused interventions. The discharge summary need not be a separate piece of paper and may be incorporated into the routine summary of reports already furnished to the physician.

N) A copy of appropriate patient transfer information, when requested, if the patient is transferred to another health facility or health agency.

2) Each agency shall have a written policy on records procedures and shall retain records for a minimum of five years beyond the last date of service provided. These procedures may include that the agency will use and maintain faxed copies of records from licensed professionals, rather than original records, provided that the faxed copies shall be maintained on non-thermal paper and that the original records shall be maintained for a period of five years by the professional who originated the records. If the professional is providing services through a contract with the agency, then the contract shall include that the professional shall maintain the original records for a period of five years.

3) Those agencies that are subject to the Local Records Act should note that, *except as otherwise provided by law, no public record shall be disposed of by any officer or agency unless the written approval of the appropriate Local Records Commission is first obtained*. (Section 7 of the Local Records Act)

4) Each agency shall have a written policy and procedure for the protection of confidentiality of patient records that explains the use of records, removal of records and release of information.

i) Drugs and Biologicals. The agency shall have written policies governing the supervision and administration of drugs and biologicals that shall include, but not be limited to, the following:

1) All orders for medications to be given shall be dated and signed by the patient's physician or podiatrist.

2) Drugs and treatments are administered by agency staff only as ordered by the physician, with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per agency policy developed in consultation with a physician, and after an assessment of the patient.

3) All orders for medications shall contain the name of the drug, dosage, frequency, method or site of injection, and permission from the patient's physician or podiatrist if the patient, the patient's family, or both are to be taught to give medications.

4) The agency's physician or podiatrist or registered nurse shall check all medicines a patient may be taking to identify possible ineffective drug therapy or adverse reactions, significant side effects, drug allergies, and contraindicated medications, and shall promptly report any problem to the patient's physician or podiatrist.

5) All verbal orders for medication or change in medication orders shall be taken by the registered nurse, written, and signed by the patient's physician or podiatrist within 30 days after the verbal order.

6) When any experimental drug, sera, allergenic desensitizing agent, penicillin or other potentially hazardous drug is administered, the registered nurse administering the drugs shall have an emergency plan and any drugs and devices that may be necessary in the event of a drug reaction.

j) Evaluation. The home health agency shall have written policies and shall make an overall evaluation of the agency's total program at least once a year. This evaluation shall be made by the Professional Advisory Group (or a committee of this group), home health agency staff, consumers, or representation from professional disciplines that are participating in the provision of home health services. The evaluation shall consist of an overall policy and administrative review and a clinical record review. The evaluation shall assess the extent to which the agency's program is appropriate, adequate, effective and efficient. Results of the evaluation shall be reported and acted upon by those responsible for the operation of the agency and maintained separately as administrative records.

k) Policy and Administrative Review. As a part of the evaluation process, the policies and administrative practices of the agency shall be reviewed to determine the extent to which they promote patient care that is appropriate, adequate, effective and efficient. Mechanisms shall be established in writing for the collection of pertinent data to assist in evaluation. The data to be considered may include, but are not limited to: number of patients receiving each service offered; number of patient visits; reasons for discharge; breakdown by diagnosis; sources of referral; number of patients not accepted, with reasons and total staff days for each service offered.

l) Clinical Record Review

1) At least quarterly, members of professional disciplines representing at least the scope of the agency's programs shall review a sample of both active and closed clinical records to assure that established policies are followed in providing services (direct, as well as those under contractual arrangement). This review shall include, but not be limited to, whether the:

A) Patient care plan was directly related to the stated diagnosis and plan of treatment;

B) Frequency of visits was consistent with the plan of treatment; and

C) Services could have been provided in a shorter span of time.

2) Clinical records shall be reviewed continually for each 62-day period that a patient received home health services to determine the adequacy of the plan of treatment and the appropriateness of continuing home health care.

(Source: Added at 31 Ill. Reg. _____, effective _____)

Section 245.205 Services – Home Nursing Agencies

a) Each home nursing agency shall provide skilled nursing services. Home nursing services may be provided directly by agency staff or through a contractual purchase of services. All services shall be provided in accordance with the orders of the client's physician or podiatrist, or provided by a health care professional who has a working agreement with a physician and under the constraints of Illinois law that allows the individual to prescribe orders, such as a physician's assistant or advance practice nurse, under a plan of treatment established by the physician, podiatrist, or prescribing professional, and under the supervision of agency staff.

b) The agency shall state in writing to the client what services will be provided directly by agency staff, and what services will be provided under contractual arrangements.

c) Acceptance and Discharge of Patients

1) Patient acceptance and discharge policies shall include, but not be limited to, the following:

A) Persons shall be accepted for services with a plan of treatment established by the patient's health care professional. This plan shall be promulgated in writing within 30 days after acceptance and shall be signed by the prescribing professional within 45 days after acceptance.

B) Prior to acceptance, the person shall be promulgate informed of the agency's charges for the various services that it offers.

C) No person shall be refused service because of age, race, color, sex, marital status, national origin or sexual orientation. Patients are accepted for treatment on the basis of a reasonable expectation that

the patient's nursing needs can be met adequately in the patient's place of residence.

D) When services are to be terminated by the agency, the patient is to be notified three working days in advance of the date of termination. The notice shall state the reason for termination. This information shall be documented in the clinical record. When indicated, a plan shall be developed or a referral made for any continuing care.

E) Services shall not be terminated until such time as the registered nurse has provided a minimum of three days notice to the patient's health care professional.

d) Plan of Treatment

1) Skilled nursing services shall be in accordance with a plan based on the client's diagnosis, an assessment of the client's immediate and long-range needs and resources, and client participation. The plan is to be established in consultation with the nursing personnel; the client's health care professional; other pertinent members of the agency staff; the client; and client's advocate. The plan shall include:

A) Diagnoses;

B) Client limitations and prognosis;

C) Expected outcomes for the client;

D) The prescribing professional's regimen of care designed to address identified client needs, including medications; treatments; activity; diet; specific procedures deemed essential for the health and safety of the client; mental status; and potential for discharge; and

E) The types and frequency of services to be provided.

e) Consultation with the client's health care professional on any modifications in the plan of treatment deemed necessary shall be documented, and the prescribing

professional's signature shall be obtained within 45 days after any modification of the plan.

1) The home nursing services team shall review the plan every 90 days, or more often should the patient's condition warrant.

2) An updated plan of treatment shall be given to the client's health care professional for review, for any necessary revisions, and for signature every 90 days, or more often as indicated.

f) Clinical Records

1) Each client shall have a clinical record maintained by the agency in accordance with accepted professional standards. Clinical records shall contain:

A) Appropriate identifying information for the client, household members and caretakers;

B) A plan of treatment developed by the home nursing agency in accord with the health care professional's order;

C) A list of medications the client is taking updated as needed. The list shall specify the dose, method, route of administration, and frequency of administration of each medication. All potential contraindications, drug interactions, and adverse reactions shall be reported to the health care professional within 24 hours, or sooner as warranted, and documented in the clinical record;

D) Initial and periodic client assessments by the registered nurse;

E) Signed and dated clinical notes for each contact that are written the day of service and incorporated into the client's clinical record at least weekly;

F) Reports on all client conferences;

G) Report of contracts with the client's health care professional by client and staff;

H) Indication of supervision of services by the supervising nurse, a registered nurse, or other members of the home nursing supervisory/management team;

I) Written and signed confirmation of the client's health care professional's interim verbal orders;

J) A discharge summary giving a brief review of service, client status, reason for discharge, and plans for post-discharge needs of the client. A discharge summary may suffice as documentation to close the client record for one-time visits or short-term services;

K) A copy of appropriate client transfer information, when requested, if the client is transferred to another health facility or health agency.

2) Each agency shall have a written policy on records procedures and shall retain records for a minimum of five years beyond the last date of service provided. The procedures may include that the agency will use and maintain faxed copies of records from licensed professionals, rather than original records, provided that the faxed copies will be maintained on non-thermal paper and that the original records will be maintained for a period of five years by the professional who originated the records. If that professional is providing services through a contract with the agency, then the contract shall provide that the professional maintain the original records for a period of five years.

3) Agencies that maintain client records by computer rather than hard copy may use electronic signatures. The agency shall have policies and procedures in place in regard to such entries and the appropriate authentication and dating of those records. Authentication may include signatures, written initials, or computer secure entry by a unique identifier of a primary author who has received and approved the entry. The agency shall have safeguards in place to prevent unauthorized access to the records and a process for reconstruction of the records in the event of a system failure or breakdown.

4) Those agencies that are subject to the Local Records Act should note that, *except as otherwise provided by law, no public record shall be disposed of by any officer or agency unless the written approval of the appropriate Local Records Commission is first obtained.* (Section 7 of the Local Records Act)

5) Each agency shall have a written policy and procedure for the protection of confidentiality of client records that explains the use of records, removal of records and release of information.

g) Drugs and Biologicals
The agency shall have written policies governing the supervision and administration of drugs and biologicals, which shall include, but not be limited to, the following:

1) All orders for medications to be given shall be dated and signed by the client's health care professional.

2) All orders for medications shall contain the name of the drug, dosage, frequency, method, and route of administration, and permission from the prescribing professional if the client, the client's family, or both are to be taught to give medications.

3) All verbal orders for medication or change in medication orders shall be taken by the registered nurse, written, and signed by the patient's healthcare professional within 45 days.

4) When any experimental drug, sera, allergenic desensitizing agent, penicillin or other potentially hazardous drug is administered, the registered nurse administering the drugs shall have an emergency plan and any drugs and devices that may be necessary in the event of a drug reaction.

(Source: Added at 31 Ill. Reg. _____, effective _____)

Section 245.210 Services – Home Services Agencies

a) Agencies licensed as home services agencies shall provide non-medical services that are intended to assist clients with activities of daily living, which would

include, but not be limited to, activity of daily living support, personal care, medication reminding, housekeeping services, personal laundry, cooking, shopping, assistance in getting to and from appointments, maintenance of household records, and companionship. Each agency shall maintain a listing of the types of services offered by the agency, and the scope of the work to be provided under each area, which the agency shall distribute to clients before contracting with the client, with the signed contract, and annually thereafter.

b) When services are provided to clients by a home services agency, there shall be a written contractual agreement between the client and the agency that includes, but is not limited to:

1) Indication and assurance of compliance by the agency with the requirements of the licensing Act, including the Health Care Worker Background Check Act;

2) Identification of parties responsible for payment of employment taxes, Social Security taxes, and workers' compensation;

3) Information on the parties responsible for supervising workers, as well as hiring, firing and discipline of in-home services workers;

4) Identification of the charges to be paid, payment schedule, and to whom the client, or person acting on behalf of the client, is to make payments for services under the contract;

5) Time period for contractual arrangement and conditions for termination of contract; and

6) Contact information for the client to use in case of concerns, complaints, or questions on care to be provided.

c) Acceptance of Clients. Home Services Agencies shall develop and follow policies on acceptance and discharge of clients, which shall include, but not be limited to, the following:

1) Persons shall be accepted for service on the basis of their desire or need for household or personal support and/or companionship services. A home services agency shall not provide medical services that would be

performed by an agency licensed as a home health agency or home nursing agency.

2) No person shall be refused services based on age, race, color, sex, marital status or national origin.

3) When services are terminated by the agency, the client is to be notified at least three working days in advance of the date of termination, with a stated reason for the termination. This information shall be maintained in the client record. The three-day notice requirement is not applicable in cases in which the worker's safety is at risk. In such cases, the agency may notify the client of termination of services and the reason for termination. Documentation of the risk to the provider shall be maintained in the client record.

d) Plan of Service. The agency shall establish a plan for each client, in consultation with the client and his or her appropriate family members or representative, that outlines the services to be provided to the client. The plan shall address and include, but not be limited to:

1) The level, type and/or scope of services the client is receiving;

2) Identification of any functional limitations of the client and the relevance of the limitation to the services to be provided;

3) Information received from the client, in consultation with the client and his or her appropriate family members or representative on circumstances that may have an impact on activity or involvement by the client, including basic information on medications being taken, treatments received, activity, diet and mental status.

e) Physician signature is not required for the plan of service developed under this Section.

f) The service plan shall be reviewed and revised as necessary, but not less than once annually.

g) Client Records. A client record shall be maintained for each client receiving in-home services. The record shall contain:

1) Appropriate identifying information for the client, including the client's name, address and telephone numbers;

2) The name, telephone numbers and address of the client's representative, if applicable;

3) The name, telephone numbers and address of an individual or relative to be contacted in an emergency;

4) The plan of services agreed to by the client and agency;

5) A copy of the Client Home Care Services Agreement or Contract; and

6) Documentation of each of the services provided at each visit.

h) Each agency shall have a written policy on records procedures and shall retain records for a minimum of two years beyond the last date of service provided.

i) Each agency shall have a written policy for protecting the confidentiality of patient records that explains the use of records, removal of records, and release of information.

(Source: Added at 31 Ill. Reg. _____, effective _____)

Section 245.212 Services – Home Nursing Placement Agency

a) Agencies licensed as home nursing placement agencies are in the business of securing or attempting to secure work for hire for persons seeking work or workers for employers.

b) A placement agency, by definition, cannot be the employer of the worker.

c) A placement agency must identify itself as a placement agency in all advertisement and marketing materials.

d) The placement agency shall require and document that:

1) An individual seeking to be placed on the placement agency's registry shall submit to a criminal background check;

2) Anyone seeking to be placed on the placement agency's registry shall undergo a competency evaluation prior to placement to ensure that the individual is competent to provide the services that the consumer is seeking; and

3) Anyone seeking to retain an active listing on the placement agency's registry, even after an initial placement, shall participate in a minimum of eight hours of in-service training per year, provided and arranged for by the placement agency.

e) The placement agency shall notify the worker both verbally and in writing of the implications of the worker's relationship to the client as the worker's employer. The document must be printed in no less than 12 point type and shall include at least the following elements in the body or through supporting documents or attachments, indicating the responsible parties for the following:

1) Employer of the licensed worker;

2) Liability for the licensed worker;

3) Payment of wages to the licensed worker;

4) Payment of employment taxes, unemployment insurance, and worker's compensation for the licensed worker;

5) Payment of Social Security taxes for the licensed worker;

6) Day-to-day supervision of the licensed worker;

7) Assignment of duties to the licensed worker;

8) Responsibility for hiring, firing and discipline of the licensed worker; and

9) Provision of equipment or materials for the licensed worker's use in providing services to the consumer.

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF PROPOSED AMENDMENTS

(Source: Added at 31 Ill. Reg. _____, effective _____)

Section 245.214 Services – Home Services Placement Agency

a) Agencies licensed as home services placement agencies are in the business of securing or attempting to secure work for hire for persons seeking work or workers for employers.

b) A placement agency, by definition, cannot be the employer of the worker.

c) A placement agency must identify itself as a placement agency in all advertisement and marketing materials.

d) The placement agency shall require and document that:

1) An individual seeking to be placed on the placement agency's registry shall submit to a criminal background check;

2) Anyone seeking to be placed on the placement agency's registry shall undergo eight hours of training pursuant to Section 245.71(c) of this Part prior to his or her first placement;

3) Anyone seeking to be placed on the placement agency's registry shall undergo a competency evaluation prior to placement to ensure that the individual is competent to provide the services that the consumer is seeking; and

4) Anyone seeking to retain an active listing on the placement agency's registry, even after an initial placement, shall participate in a minimum of eight hours of in-service training per year, provided and arranged for by the placement agency.

e) The placement agency shall notify the worker both verbally and in writing of the implications of his or her relationship to the client as his or her employer. The document must be printed in no less than 12 point type and shall include at least the following elements in the body or through supporting documents or attachments, indicating the responsible parties for the following:

1) Employer of the in-home services worker;

2) Liability for the in-home services worker;

3) Payment of wages to the in-home services worker;

4) Payment of employment taxes, unemployment insurance, and worker's compensation for the in-home services worker;

5) Payment of Social Security taxes for the in-home services worker;

6) Day-to-day supervision of the in-home services worker;

7) Assignment of duties to the in-home services worker;

8) Responsibility for hiring, firing, and discipline of the in-home services worker; and

9) Provision of equipment or materials for the in-home services worker's use in providing services to the consumer.

(Source: Added at 31 Ill. Reg. _____, effective _____)

Section 245.220 Client Service Contracts – Home Nursing and Home Services Agencies

A contract between a home nursing or home services agency and a client shall be in force, a copy of which is provided to the client and a copy of which is maintained in the client file at the agency. The document shall be printed in no less than 12 point type, and shall include at least the following elements in the body or through supporting documents or attachments:

a) Client consent to receive services;

b) The name, street address and mailing address of the agency;

c) The name and mailing address of the persons designated as the agency manager and/or other individual beyond the in-home worker to contact in regard to questions, problems, needs or concerns;

d) A statement describing the agency license status;

e) The duration of the contract;

f) The rate to be paid by the client and a detailed description of services to be provided as a part of the rate;

g) A description of the process through which the contract may be modified, amended or terminated;

h) A description of the agency complaint resolution process;

i) The billing and payment procedures and requirements;

j) A statement regarding the agency's policy on notification of a relative or other individual in case of an emergency;

k) A notice as developed and provided by the Department, indicating the responsible party for the following:

1) Employer of the in-home/licensed worker;

2) Liability for the in-home/licensed worker;

3) Payment of wages to the in-home/licensed worker;

4) Payment of employment taxes, unemployment insurance, and worker's compensation for the in-home/licensed worker;

5) Payment of Social Security taxes for the in-home/licensed worker;

6) Day-to-day supervision of the in-home/licensed worker;

7) Assignment of duties to the in-home/licensed worker;

8) Responsibility for hiring, firing and discipline of the in-home/licensed worker; and

9) Provision of equipment or materials for the in-home/licensed worker's use in providing services to the consumer.

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF PROPOSED AMENDMENTS

(Source: Added at 31 Ill. Reg. _____, effective _____)

Section 245.225 Client Service Contracts – Home Nursing Placement Agency and Home Services Placement Agency

A contract between a home nursing placement agency or home services placement agency and a client shall be in force, a copy of which is provided to the client and a copy of which is maintained in the client file at the agency. The document shall be printed in no less than 12 point type, and shall include at least the following elements in the body or through supporting documents or attachments:

a) Client consent to receive services;

b) The name, street address and mailing address of the agency;

c) The name and mailing address of the persons designated as the placement agency manager and/or other individual representing the placement agency whom the consumer may contact in the event that the contract terms are not performed;

d) A statement describing the agency license status;

e) The duration of the contract;

f) The rate to be paid by the client and a detailed description of services to be provided as a part of the rate;

g) A description of the process through which the contract may be modified, amended or terminated;

h) A description of the agency complaint resolution process;

i) The billing and payment procedures and requirements;

j) A statement regarding the agency's policy on notification of a relative or other individual in case of an emergency;

k) A statement on how the client can report abuse, neglect or financial exploitation;

l) A notice, as developed and provided by the Department, indicating the responsible party for the following:

1) Employer of the in-home/licensed worker;

2) Liability for the in-home/licensed worker;

3) Payment of wages to the in-home/licensed worker;

4) Payment of employment taxes, unemployment insurance, and worker's compensation for the in-home/licensed worker;

5) Payment of Social Security taxes for the in-home/licensed worker;

6) Day-to-day supervision of the in-home/licensed worker;

7) Assignment of duties to the in-home/licensed worker;

8) Responsibility for hiring, firing and discipline of the in-home/licensed worker; and

9) Provision of equipment or materials for the in-home/licensed worker's use in providing services to the consumer.

(Source: Added at 31 Ill. Reg. _____, effective _____)

Section 245.240 Quality Improvement Program

a) Each agency shall develop a quality improvement program for the agency. The quality improvement program shall include written policies and shall evaluate the agency's total program at least once a year. The evaluation shall, at a minimum, include a clinical or client record review, as appropriate. This evaluation shall assess the extent to which the agency's program is appropriate, adequate, effective and efficient. Results of the evaluation shall be reported to and acted upon by those responsible for the operation of the agency and shall be maintained separately as administrative records.

b) Record Review. At least quarterly, the agency shall review a sample of both active and closed clinical or client records to assure that established policies are

followed in providing services (direct services, as well as those under contractual arrangement). If applicable, this review shall include, but not be limited to:

1) Whether the care plan was directly related to the stated diagnosis and plan of care;

2) Whether the frequency of visits was consistent with the plan of care; and

3) Whether the services could have been provided in a shorter span of time or with fewer visits.

c) None of the information, interviews, reports, statements, memoranda and recommendations produced during or resulting from the agency's quality improvement program may be admissible as evidence nor discoverable in any action of any kind in any court, as provided in Article VIII, Part 21 of the Code of Civil Procedure (Medical Studies).

(Source: Added at 31 Ill. Reg. _____, effective _____)

Section 245.250 Abuse, Neglect and Financial Exploitation Prevention and Reporting

a) When an agency has reasonable suspicion that a client has been the victim of abuse, neglect or financial exploitation, the agency shall do the following:

1) In the case of an individual who is 60 years of age or older, an individual who has been found to be disabled or one who otherwise qualifies as an "eligible adult" under the Elder Abuse and Neglect Act, the agency shall notify the elder abuse provider agency designated by the Department on Aging or an Area Agency on Aging for the area in which the client resides. The agency shall document this report and maintain documentation on the premises for 12 months after the date of the report.

2) In the case of an alleged victim under the age of 18, the agency shall notify the Department of Children and Family Services through the Child Abuse Hotline. The agency shall document this report and maintain documentation on the premises for 12 months after the date of the report.

3) If the abuse or neglect is alleged to be a result of actions by an employee of the agency, or one placed by an agency providing in-home, home

health, or home nursing services, the agency shall immediately remove the alleged perpetrator from direct contact with clients and investigate the allegation.

b) In cases of allegations of abuse or neglect by an employee or an individual who has been placed by an agency, the agency shall conduct an investigation and develop a written report of the findings of the investigation within 14 days after the initial report. The agency shall send the written report of the investigation to the Department within 24 hours after completion of the investigation and shall maintain a copy of the report on the agency premises for 12 months after the date of the report.

c) The written report of the investigation conducted pursuant to this Section shall contain at least the following:

1) Dates, times and description of alleged abuse, neglect or financial exploitation;

2) Description of injury or abuse to client;

3) Any actions taken by the licensee;

4) A list of individuals and agencies interviewed or notified by the licensee;

5) A description of the action to be taken by the licensee to prevent the abuse, neglect or financial exploitation from occurring in the future; and

6) Statements of any witnesses.

d) Agency employees and volunteers shall report abuse, neglect or financial exploitation of a client to the agency management and to the appropriate elder abuse provider agency or the Illinois Department on Aging.

e) The agency shall immediately contact local law enforcement authorities (e.g., telephoning 911 where available) in the following situations:

1) Physical abuse involving physical injury inflicted on a patient and/or client by a staff member;

2) Sexual abuse of a patient and/or client by a staff member;

3) When a crime has been committed in the patient and/or client's home by a person other than the patient or client;

4) When a patient or client's death has occurred other than by disease processes; or

5) When an allegation of physical abuse, sexual abuse or crime has been reported, or when death (other than by disease or natural causes) has occurred to a patient and/or client.

f) The agency shall develop and implement a policy concerning local law enforcement notification, including:

1) Ensuring the safety of patients and/or clients in situations requiring local law enforcement notification;

2) Contacting local law enforcement in situations involving physical abuse of a patient and/or client by another person;

3) Contacting police, fire, ambulance and rescue services; and

4) Seeking advice concerning preservation of a potential crime scene.

g) Nothing in this Section relieves a mandates reporter from the responsibility of making a report to an agency designated to receive such reports under the Elder Abuse and Neglect Act or to the Department.

(Source: Added at 31 Ill. Reg. _____, effective _____)

ILLINOIS RACING BOARD

NOTICE OF PROPOSED AMENDMENTS

1) Heading of the Part: Claiming Races

2) Code Citation: 11 Ill. Adm. Code 510

3)

Section Numbers:	Proposed Action:
510.60	Amend
510.200	Amend

4) Statutory Authority: 230 ILCS 5/9(b)

5) A Complete Description of the Subjects and Issues Involved: This proposed rulemaking prohibits a harness driver from claiming a horse that he or she is driving. To avoid a conflict of interest, most racing jurisdictions, including New Jersey, Indiana and Delaware, prohibit drivers from claiming horses they are driving. In addition, the United States Trotting Association rulebook contains a rule that states that no person shall claim his own horse, nor shall he claim a horse trained or driven by him.

This proposed rulemaking also creates a draw by lot in the event a trainer, on behalf of multiple owners, submits multiple claims for the same horse.

Finally, this proposed rulemaking would prevent a horse that is claimed at an Illinois racetrack from leaving the State for 60 days. The current rule permits a claimed horse to leave the State after 60 days or the end of the meet, whichever is shorter. The proposal would not apply to horses claimed at Fairmount Park and would benefit field sizes in Illinois by not allowing claimed horses to leave at the end of a race meet and within 60 days after the claim.

6) Published studies or reports, and sources of underlying data, used to compose this rulemaking: United States Trotting Association Rules and Regulations, Rule 10, Section 2, subsection a.

7) Will this rulemaking replace any emergency rulemaking currently in effect? No

8) Does this rulemaking contain an automatic repeal date? No

9) Does this rulemaking contain incorporations by reference? No

10) Are there any other proposed rulemakings pending on this Part? No

ILLINOIS RACING BOARD

NOTICE OF PROPOSED AMENDMENTS

11) Statement of Statewide Policy Objectives: No local governmental units will be required to increase expenditures.

12) Time, Place and Manner in which interested persons may comment on this proposed rulemaking: Written comments should be submitted, within 45 days after this Notice, to:

Mickey Ezzo
Illinois Racing Board
100 West Randolph
Suite 7-701
Chicago, Illinois 60601

312/814-5017

13) Initial Regulatory Flexibility Analysis:

A) Types of small business affected: None

B) Reporting, bookkeeping or other procedures required for compliance: None

C) Types of professional skills necessary for compliance: None

14) Regulatory Agenda which this rulemaking was summarized: This rulemaking was not included on either of the two most recent regulatory agendas because: this rulemaking was not anticipated by the Board when the two most recent regulatory agendas were published.

The full text of the Proposed Amendments begins on the next page.

ILLINOIS RACING BOARD

NOTICE OF PROPOSED AMENDMENTS

TITLE 11: ALCOHOL, HORSE RACING, AND LOTTERY
SUBTITLE B: HORSE RACING
CHAPTER I: ILLINOIS RACING BOARD
SUBCHAPTER c: RULES APPLICABLE TO ALL OCCUPATION LICENSEES

PART 510
CLAIMING RACES

Section

510.10 Definition
510.20 Claiming Eligibility
510.30 Form and Deposit of Claim
510.40 Errors which Invalidate Claim
510.50 Refund of Voided Claim
510.60 Prohibited Action with Respect to Claim
510.70 Horses under Lien
510.80 Affidavit May be Required
510.90 Claimant's Responsibility
510.100 Claimed Horse's Certificate
510.110 Engagements of a Claimed Horse
510.120 Protests of a Claim
510.130 Title to a Claimed Horse
510.140 Distribution of the Purse
510.150 Delivery of a Claimed Horse
510.160 Trainer Responsibility for Post-Race Tests
510.170 Excusing Claimed Horse
510.180 Stable Eliminated by Fire or Other Hazard
510.190 Entering Claimed Horse (Repealed)
510.195 Determining Eligibility Dates
510.200 Claimed Horse Racing Elsewhere
510.210 Sale of a Claimed Horse
510.220 Illinois Rules Govern Claimed Horse
510.230 Extension of Regular Meeting (Repealed)
510.240 Claiming Authorization
510.250 Claiming Price

AUTHORITY: Authorized by Section 9(b) of the Illinois Horse Racing Act of 1975 [230 ILCS 5/9(b)].

ILLINOIS RACING BOARD

NOTICE OF PROPOSED AMENDMENTS

SOURCE: Adopted at 5 Ill. Reg. 1686, effective February 16, 1981; amended at 5 Ill. Reg. 8300, effective August 5, 1981; codified at 5 Ill. Reg. 10911; amended at 7 Ill. Reg. 2167, effective February 4, 1983; amended at 7 Ill. Reg. 3197, effective March 14, 1983; amended at 8 Ill. Reg. 14992, effective August 6, 1984; amended at 14 Ill. Reg. 17636, effective October 16, 1990; amended at 17 Ill. Reg. 12423, effective July 15, 1993; amended at 17 Ill. Reg. 13612, effective July 30, 1993; amended at 18 Ill. Reg. 2064, effective January 21, 1994; amended at 18 Ill. Reg. 11607, effective July 7, 1994; amended at 19 Ill. Reg. 13887, effective October 1, 1995; amended at 20 Ill. Reg. 12473, effective September 1, 1996; amended at 21 Ill. Reg. 951, effective January 7, 1997; amended at 24 Ill. Reg. 7386, effective May 1, 2000; amended at 24 Ill. Reg. 12722, effective August 1, 2000; amended at 24 Ill. Reg. 17480, effective November 8, 2000; amended at 25 Ill. Reg. 6393, effective May 1, 2001; amended at 25 Ill. Reg. 8814, effective July 1, 2001; amended at 27 Ill. Reg. 533, effective January 1, 2003; amended at 31 Ill. Reg. _____, effective _____.

Section 510.60 Prohibited Action with Respect to Claim

No person or racing interest shall:

a) claim more than one horse from any one race;

b) claim their own horse or cause such horse to be claimed, directly or indirectly, for their own account;

c) refuse to deliver the claimed horse to the successful claimant; furthermore, the horse in question shall be disqualified until delivery is effected;

d) make any agreement with any other person or racing interest for the protection of each other's horses in any claiming race;

e) remove any horse which has been entered in a claiming race from the race track where it has been entered to race;

f) fail or refuse to comply with any rule or condition of the meeting for the purpose of avoiding or preventing a claim for such horse;

g) offer, or enter into an agreement to claim or not to claim or attempt to prevent another person from claiming any horse in a claiming race;

h) attempt to intimidate or prevent anyone from running a horse in any claiming

race;

i) claim horses owned or trained by their trainer or the trainer's spouse, child, sibling, parent, mother-in-law or father-in-law;

j) claim horses owned or trained by their own spouse, child, sibling, parent, mother-in-law or father-in-law;.

k) claim, directly or indirectly, a horse he or she is driving in a race;

l) claim a horse without designating a licensed trainer. In the event multiple owners designate the same trainer for a single claim, a preliminary drawing between those owners shall be determined by lot under the supervision of the Stewards or their duly appointed representative. The winner of the preliminary drawing shall be the participant in the final draw. In the event that there are no other claimants, the winner of the preliminary draw shall be the sole claimant.

(Source: Amended at 31 Ill. Reg. _____, effective _____)

Section 510.200 Claimed Horse Racing Elsewhere

a) Horses claimed at race tracks located in the Chicagoland area shall not race at any other race track for 60 days except at another race track located in the Chicagoland area. Race tracks located within 50 miles of the City of Chicago shall be considered in the Chicagoland area. However, a claimed horse may race at another race track when a race meeting concludes and no race meeting starts in the Chicagoland area for 30 days.No claimed horse shall race at any other race track until the close of the race meeting at which it was claimed, or for 60 days, whichever is shorter.

b) Horses claimed at race tracks located outside the Chicagoland area shall not race at any other race track until the close of the race meeting, or for 60 days, whichever is shorter.

cb) This Section shall not apply when claimed horses are fulfilling a stakes engagement or have the express written consent, of the race track where they were claimed, to race at another location.

(Source: Amended at 31 Ill. Reg. _____, effective _____)

ILLINOIS RACING BOARD

NOTICE OF PROPOSED RULES

1) Heading of the Part: Horse Health

2) Code Citation: 11 Ill. Adm. Code 605

3)

Section Numbers:	Proposed Action:
605.10	New Section
605.20	New Section
605.30	New Section
605.40	New Section
605.50	New Section
605.60	New Section
605.70	New Section
605.80	New Section
605.90	New Section
605.100	New Section

4) Statutory Authority: 230 ILCS 5/9(b)

5) A Complete Description of the Subjects and Issues Involved: This proposed rulemaking re-organizes the Board's current rules pertaining to horse health for both harness and thoroughbred racing.

6) Published studies or reports and sources of underlying data used to compose this rulemaking: None

7) Will this rulemaking replace any emergency rulemaking currently in effect? Yes

8) Does this rulemaking contain an automatic repeal date? No

9) Does this rulemaking contain incorporations by reference? No

10) Are there any other proposed rulemakings pending on this Part? No

11) Statement of Statewide Policy Objectives: No local governmental units will be required to increase expenditures.

12) Time, Place and Manner in which interested persons may comment on this proposed rulemaking: Written comments should be submitted, within 45 days after this Notice, to:

ILLINOIS RACING BOARD

NOTICE OF PROPOSED RULES

Mickey Ezzo
Illinois Racing Board
100 West Randolph
Suite 7-701
Chicago, Illinois 60601

312/814-5017

13) Initial Regulatory Flexibility Analysis:

A) Types of small businesses, small municipalities and not-for-profit corporations affected: None

B) Reporting, bookkeeping or other procedures required for compliance: None

C) Types of professional skills necessary for compliance: None

14) Regulatory Agenda which this rulemaking was summarized: This rulemaking was not included on either of the two most recent regulatory agendas because: this rulemaking was not anticipated by the Board when the two most recent regulatory agendas were published.

The full text of the Proposed Rules begins on the next page:

ILLINOIS RACING BOARD

NOTICE OF PROPOSED RULES

TITLE 11: ALCOHOL, HORSE RACING, AND LOTTERY
SUBTITLE B: HORSE RACING
CHAPTER I: ILLINOIS RACING BOARD
SUBCHAPTER c: RULES APPLICABLE TO ALL OCCUPATION LICENSEES

PART 605
HORSE HEALTH

Section

605.10 State Veterinarian and Veterinarian's List
605.20 Report Deceased and Sick Horses
605.30 Observe Sanitary, Safety, Humane Rules
605.40 Valid Health Certificate
605.50 Coggins Test
605.60 Equine Herpesvirus (EHV-1)
605.70 Sterile Equipment and Disposable Needles
605.80 Bandages
605.90 Humane Treatment of Horses
605.100 Pest Control and Clean Equipment

AUTHORITY: Authorized by Section 9(b) of the Illinois Horse Racing Act of 1975 [230 ILCS 5/9(b)].

SOURCE: Adopted at 31 Ill. Reg. _____, effective _____.

Section 605.10 State Veterinarian and Veterinarian's List

a) The State Veterinarian shall report to the Stewards all examinations and inspections of any horse or premises under the jurisdiction of the Board.

b) The State Veterinarian may establish procedures, relative to this Part, that will govern all practicing veterinarians at the race track.

c) The State Veterinarian shall be consulted about any alleged violations of this Part. Investigations will be made and reported promptly to the Board. The Board may suspend or revoke the license of any person violating this Part.

d) The State Veterinarian shall maintain a veterinarian's list and any horse excused through sickness or disability shall be placed on the list. Any horse placed on the

list shall not be permitted to enter or start in a race until its name is removed from the list.

e) In thoroughbred racing, horses shall remain on the veterinarian's list at least five calendar days, unless, in the opinion of the State Veterinarian its name should be removed earlier. A workout at a distance specified by the State Veterinarian may be required prior to removing a horse from the list. The owner or trainer of a horse to be placed on the veterinarian's list for soreness or lameness by one of the State Veterinarians may request a second opinion from the Association Veterinarian. The veterinarians shall then reach a mutual decision.

f) At the close of each meeting, the State Veterinarians shall make a written report to the Board of the conditions of the meeting and any recommendations they deem advisable.

Section 605.20 Report Deceased and Sick Horses

a) The attending veterinarian and the trainer shall report immediately to the State Veterinerian:

1) Castrations, neurectomies, and all major surgical procedures.

2) Contagious and "exotic" appearing diseases.

3) Deceased horses.

4) Sick or disabled horses.

b) No deceased or sick horse may be removed from the grounds of a licensed race track operator without the prior approval of the State Veterinarian's office.

Section 605.30 Observe Sanitary, Safety, Humane Rules

A trainer shall see to it that the stables and immediate surrounding area assigned to him or her are sanitary at all times and that the humane laws of the State of Illinois are observed, and that the fire prevention rules (especially no-smoking in the stable area) are strictly observed at all times. Constant misuse of property will be considered when stall assignments are made.

Section 605.40 Valid Health Certificate

A certificate of veterinary inspection and entry permit are not required for Illinois equine. Illinois equine traveling out of the State, for 30 consecutive days or less, on an Illinois certificate of veterinary inspection are not required to obtain a permit to return home. If, however, Illinois equine are out of the State longer than 30 days (i.e., boarding, training), a certificate of veterinary inspection issued by the state where the animal has been residing and an entry permit will be required. Once an animal has been out of the State longer than 30 days, it is no longer recognized as being an Illinois native animal. All equine entering Illinois for any reason other than slaughter must be accompanied by a negative test for equine infectious anemia (EIA) conducted within a year if the animal is more than one year of age, certificate of veterinary inspection issued by an accredited veterinarian within 30 days prior to entry, and an entry permit number issued by the Illinois Department of Agriculture. The organization licensee shall be responsible for compliance with this Section.

Section 605.50 Coggins Test

Horses racing in Illinois must have a negative Coggins test done at least once every 12 months. A current negative test certificate from a laboratory, approved by the U.S. Department of Agriculture, must be on file with the Racing Secretary. Trainers that start a horse without having a current negative test certificate on file with the Racing Secretary may be fined. The State Veterinarian may draw blood from any horse on the grounds for the purpose of conducting the Coggins test. Horses having a positive Coggins test must be removed from the race track under the direction of the State Veterinarian.

Section 605.60 Equine Herpesvirus (EHV-1)

All horses, including ponies, entering or stabling on the grounds of any pari-mutuel racetrack in Illinois shall have documented proof of EHV-1 vaccination administered within the prior 90 days. No entries shall be accepted by the Racing Secretary without documented proof of a current EHV-1 vaccination. The Racing Secretary shall maintain records to substantiate current vaccinations of all horses entering or stabling on the grounds.

Section 605.70 Sterile Equipment and Disposable Needles

a) Veterinarians practicing on a race track where a race meet is in progress or imminent shall use one time disposable needles and shall dispose of them in an approved manner.

b) No person other than a licensed veterinarian may have a needle or syringe of any kind, type or description, or an injectable drug, on his or her person or in his or her custody, or in the control, custody or possession of any of his or her employees.

Section 605.80 Bandages

The paddock judge or paddock veterinarian shall inspect bandages just prior to the participation in a race of the horse on which they are used. The judge or veterinarian may order removal and replacement of bandages if they see fit to do so. Any circumstances in the use of bandages that indicate fraud shall be reported to the Stewards. In thoroughbred racing, cold water bandages, ice-boots, or bandages of a similar nature must be removed when a horse enters the paddock for a race and may not be used for racing purposes.

Section 605.90 Humane Treatment of Horses

a) No person shall subject any animal to any form of cruelty, mistreatment, neglect, abuse, abandonment, or injury on the grounds of an organization licensee.

b) No person shall deprive any animal of necessary care, sustenance, shelter or veterinary care on the grounds of an organization licensee.

Section 605.100 Pest Control and Clean Equipment

a) The race track operator shall maintain systematic, effective control against flies, mosquitoes, other insects and rats at all times during a meeting. Horses must be stabled in individual box stalls with appropriate feeding and watering facilities. Stables and immediate surrounding areas must be disinfected and kept in a sanitary condition at all times. Satisfactory drainage must be provided and manure and other refuse must be promptly and properly removed. These regulations apply to any stabling areas that the Board has approved for the race track operator. The Board or its official representatives will make periodic inspections of a track. Failure to comply with sanitary practices or to provide any pest control will result in loss of racing dates.

b) The race track operator shall maintain paddocks, starting gates and other equipment subjected to contact by different animals so that they are disinfected, kept in a clean condition, and kept in a safe condition that does not endanger animals.

ILLINOIS RACING BOARD

NOTICE OF PROPOSED AMENDMENT

1) Heading of the Part: Race Officials

2) Code Citation: 11 Ill. Adm. Code 1306

3) Section Number: 1306.230 — Proposed Action: Repeal

4) Statutory Authority: 230 ILCS 5/9(b)

5) A Complete Description of the Subjects and Issues Involved: The proposed rulemaking repeals Section 1306.230 as the first phase of the Board's efforts to consolidate the harness and thoroughbred rules. Proposed rules have been filed concurrently to establish a new Part 605 dedicated to horse health.

6) Published studies or reports and sources of underlying data used to compose this rulemaking: None

7) Will this rulemaking replace any emergency rulemaking currently in effect? No

8) Does this rulemaking contain an automatic repeal date? No

9) Does this rulemaking contain incorporations by reference? No

10) Are there any other proposed rulemakings pending on this Part? No

11) Statement of Statewide Policy Objectives: No local governmental units will be required to increase expenditures.

12) Time, Place and Manner in which interested persons may comment on this proposed rulemaking: Written comments should be submitted, within 45 days after this Notice, to:

Mickey Ezzo
Illinois Racing Board
100 West Randolph
Suite 7-701
Chicago, Illinois 60601

312/814-5017

ILLINOIS RACING BOARD

NOTICE OF PROPOSED AMENDMENT

13) Initial Regulatory Flexibility Analysis:

A) Types of small businesses, small municipalities and not-for-profit corporations affected: None

B) Reporting, bookkeeping or other procedures required for compliance: None

C) Types of professional skills necessary for compliance: None

14) Regulatory Agenda which this rulemaking was summarized: This rulemaking was not included on either of the two most recent regulatory agendas because: the Board did not anticipate the need for this rulemaking at the time the agendas were published.

The full text of the Proposed Amendment begins on the next page:

ILLINOIS RACING BOARD

NOTICE OF PROPOSED AMENDMENT

TITLE 11: ALCOHOL, HORSE RACING, AND LOTTERY
SUBTITLE B: HORSE RACING
CHAPTER I: ILLINOIS RACING BOARD
SUBCHAPTER f: RULES AND REGULATIONS OF HARNESS RACING

PART 1306
RACE OFFICIALS

Section

1306.10 State Steward
1306.20 Additional Steward
1306.30 Judges
1306.50 Disqualification to Act as Official
1306.70 Participation Forbidden
1306.80 Judges' Stand Occupants
1306.90 Improper Conduct
1306.100 Presiding Judge
1306.110 Powers of the State Steward and Judges
1306.120 Duties of the Judges and State Steward
1306.130 Procedures of the Judges and State Steward
1306.140 Patrol Judge
1306.160 Starting Judges
1306.170 Duties of Starter
1306.180 Clerk of the Course
1306.190 Timers
1306.200 Paddock Judge
1306.210 Program Director
1306.220 Horse Identifier
1306.230 State Veterinarian (Repealed)
1306.240 Bribes Forbidden
1306.250 Drinking of Intoxicating Liquor Prohibited
1306.260 Arrival Time (Repealed)

AUTHORITY: Authorized by Section 9(b) of the Illinois Horse Racing Act of 1975 [230 ILCS 5/9(b)].

SOURCE: Published in Rules and Regulations of Harness Racing (original date not cited in publication); codified at 5 Ill. Reg. 10926; amended at 10 Ill. Reg. 10147, effective May 27,

ILLINOIS RACING BOARD

NOTICE OF PROPOSED AMENDMENT

1986; amended at 30 Ill. Reg. 16319, effective October 1, 2006; amended at 31 Ill. Reg. _____, effective _____.

Section 1306.230 State Veterinarian (Repealed)

~~a) The state veterinarian shall report to the state steward all examinations or inspections of any horse or premises under the jurisdiction of the Board.~~

~~b) He shall maintain a veterinarian's list and any horse that is ill, infirm or extremely lame shall be placed on said list. Any horse placed on said list shall not be permitted to enter in a race until his name is removed from the list.~~

(Source: Repealed at 31 Ill. Reg. _____, effective _____)

ILLINOIS RACING BOARD

NOTICE OF PROPOSED AMENDMENTS

1) Heading of the Part: General Licensee Rules

2) Code Citation: 11 Ill. Adm. Code 1313

3)

Section Numbers:	Proposed Action:
1313.20	Repeal
1313.30	Repeal
1313.90	Repeal
1313.120	Repeal
1313.130	Repeal

4) Statutory Authority: 230 ILCS 5/9(b)

5) A Complete Description of the Subjects and Issues Involved: The proposed rulemaking repeals Sections 1313.20, 1313.30, 1313.90, 1313.120, and 1313.130 as the first phase of the Board's efforts to consolidate the harness and thoroughbred rules. Proposed rules have been filed concurrently to establish a new Part 605 dedicated to horse health.

6) Published studies or reports and sources of underlying data used to compose this rulemaking: None

7) Will this rulemaking replace any emergency rulemaking currently in effect? No

8) Does this rulemaking contain an automatic repeal date? No

9) Does this rulemaking contain incorporations by reference? No

10) Are there any other proposed rulemakings pending on this Part? No

11) Statement of Statewide Policy Objectives: No local governmental units will be required to increase expenditures.

12) Time, Place and Manner in which interested persons may comment on this proposed rulemaking: Written comments should be submitted, within 45 days after this Notice, to:

Mickey Ezzo
Illinois Racing Board
100 West Randolph
Suite 7-701

ILLINOIS RACING BOARD

NOTICE OF PROPOSED AMENDMENTS

Chicago, Illinois 60601

312/814-5017

13) Initial Regulatory Flexibility Analysis:

A) Types of small businesses, small municipalities and not-for-profit corporations affected: None

B) Reporting, bookkeeping or other procedures required for compliance: None

C) Types of professional skills necessary for compliance: None

14) Regulatory Agenda which this rulemaking was summarized: This rulemaking was not included on either of the two most recent regulatory agendas because: the Board did not anticipate the need for this rulemaking at the time the agendas were published.

The full text of the Proposed Amendments begins on the next page.

ILLINOIS RACING BOARD

NOTICE OF PROPOSED AMENDMENTS

TITLE 11: ALCOHOL, HORSE RACING, AND LOTTERY
SUBTITLE B: HORSE RACING
CHAPTER I: ILLINOIS RACING BOARD
SUBCHAPTER f: RULES AND REGULATIONS OF HARNESS RACING

PART 1313
GENERAL LICENSEE RULES

Section

1313.10 Worker's Compensation (Repealed)
1313.20 Health Regulations (Repealed)
1313.30 Observe Sanitary, Safety, Humane Rules (Repealed)
1313.40 Halters
1313.48 Safety Helmets
1313.50 Equipment Change and Records
1313.60 Sulky Performance Standards
1313.70 Horses in Paddock
1313.80 Body Alcohol Testing
1313.90 Deceased and Sick Horses (Repealed)
1313.100 Firearms
1313.110 Private Practice Prohibited
1313.120 Veterinarian Reports (Repealed)
1313.130 Clean Equipment (Repealed)

AUTHORITY: Authorized by Section 9(b) of the Illinois Horse Racing Act of 1975 [230 ILCS 5/9(b)].

SOURCE: Published in Rules and Regulations of Harness Racing (original date not cited in publication); passed July 11, 1972; amended April 13, 1973; amended June 11, 1973; amended October 25, 1973, filed December 17, 1973 codified at 5 Ill. Reg. 10937; amended at 11 Ill. Reg. 14816, effective August 24, 1987; amended at 11 Ill. Reg. 20205, effective December 31, 1987; amended at 18 Ill. Reg. 15442, effective September 30, 1994; emergency amendment at 28 Ill. Reg. 5713, effective March 24, 2004, for a maximum of 150 days; emergency expired August 20, 2004; amended at 28 Ill. Reg. 12119, effective August 22, 2004; amended at 29 Ill. Reg. 19688, effective December 1, 2005; amended at 31 Ill. Reg. _____, effective _____.

Section 1313.20 Health Regulations (Repealed)

~~A certificate of veterinary inspection and entry permit are not required for Illinois equine. Illinois equine traveling out of the State on an Illinois certificate of veterinary inspection are not required to obtain a permit to return home. If, however, Illinois equine are out of the State longer than 30 days (i.e., boarding, training), a certificate of veterinary inspection issued by the state where the animal has been residing and an entry permit will be required. Once an animal has been out of the State longer than 30 days, it is no longer recognized as being an Illinois native animal. All equine entering Illinois for any reason other than slaughter must be accompanied by a negative test for equine infectious anemia (EIA) conducted within a year if the animal is more than one year of age, certificate of veterinary inspection issued by an accredited veterinarian within 30 days prior to entry, and an entry permit number issued by the Illinois Department of Agriculture. The organization licensee shall be responsible for compliance with this Section.~~

(Source: Repealed at 31 Ill. Reg. _____, effective _____)

Section 1313.30 Observe Sanitary, Safety, Humane Rules (Repealed)

~~A trainer shall see to it that the stables and immediate surrounding area assigned to him are sanitary at all times and that the humane laws of the State of Illinois be observed, also that the fire prevention rules (especially no-smoking in the stable area) be strictly observed at all times. Constant misuse of property will be considered when stall assignments are made.~~

(Source: Repealed at 31 Ill. Reg. _____, effective _____)

Section 1313.90 Deceased and Sick Horses (Repealed)

~~No deceased or sick horse may be removed from the grounds of a licensed race track operator without the prior approval of the state veterinarian's office.~~

(Source: Repealed at 31 Ill. Reg. _____, effective _____)

Section 1313.120 Veterinarian Reports (Repealed)

~~Reportable in writing within 48 hours to the state veterinarian by the attending veterinarian and the trainer are:~~

~~a) Castrations, neurectomies, and all other major surgical procedures.~~

~~b) Contagious and "exotic" appearing diseases.~~

~~c)~~ ~~Expired horses.~~

(Source: Repealed at 31 Ill. Reg. _____, effective _____)

Section 1313.130 Clean Equipment (Repealed)

~~a)~~ ~~Paddocks, starting gates and other equipment subjected to contact by different animals must be kept in a clean condition and free from dangerous surfaces by management.~~

~~Sterile equipment must be used for collecting material for the saliva and blood tests. All types of instruments used on horses, including surgical, tattooing, dental, and similar items, must be properly cleaned and sterilized by boiling for 15 minutes or autoclaving 15 minutes at 15 pounds pressure before use on each animal.~~

(Source: Repealed at 31 Ill. Reg. _____, effective _____)

ILLINOIS RACING BOARD

NOTICE OF PROPOSED AMENDMENT

1) Heading of the Part: Forbidden Conduct

2) Code Citation: 11 Ill. Adm. Code 1320

3) Section Number: 1320.150 — Proposed Action: Repeal

4) Statutory Authority: 230 ILCS 5/9(b)

5) A Complete Description of the Subjects and Issues Involved: The proposed rulemaking repeals Section 1320.150 as the first phase of the Board's efforts to consolidate the harness and thoroughbred rules. Proposed rules have been filed concurrently to establish a new Part 605 dedicated to horse health.

6) Published studies or reports and sources of underlying data used to compose this rulemaking: None

7) Will this rulemaking replace any emergency rulemaking currently in effect? No

8) Does this rulemaking contain an automatic repeal date? No

9) Does this rulemaking contain incorporations by reference? No

10) Are there any other proposed rulemakings pending on this Part? No

11) Statement of Statewide Policy Objectives: No local governmental units will be required to increase expenditures.

12) Time, Place and Manner in which interested persons may comment on this proposed rulemaking: Written comments should be submitted, within 45 days after this Notice, to:

Mickey Ezzo
Illinois Racing Board
100 West Randolph
Suite 7-701
Chicago, Illinois 60601

312/814-5017

ILLINOIS RACING BOARD

NOTICE OF PROPOSED AMENDMENT

13) Initial Regulatory Flexibility Analysis:

A) Types of small businesses, small municipalities and not-for-profit corporations affected: None

B) Reporting, bookkeeping or other procedures required for compliance: None

C) Types of professional skills necessary for compliance: None

14) Regulatory Agenda which this rulemaking was summarized: This rulemaking was not included on either of the two most recent regulatory agendas because: the Board did not anticipate the need for this rulemaking at the time the agendas were published.

The full text of the Proposed Amendment begins on the next page.

ILLINOIS RACING BOARD

NOTICE OF PROPOSED AMENDMENT

TITLE 11: ALCOHOL, HORSE RACING, AND LOTTERY
SUBTITLE B: HORSE RACING
CHAPTER I: ILLINOIS RACING BOARD
SUBCHAPTER f: RULES AND REGULATIONS OF HARNESS RACING

PART 1320
FORBIDDEN CONDUCT

Section

1320.10 Improper Conduct
1320.20 Assault and/or Battery
1320.30 Conspiracy Not to Race
1320.40 Demand Special Rewards
1320.50 Betting On Starters
1320.60 Fraudulent Proposals
1320.70 Acts Injurious to Racing
1320.80 Conspiracy to Violate Rules
1320.90 Sworn Oaths
1320.100 Association with Undesirables
1320.110 Bookmaking
1320.120 Solicitation of Wagers
1320.130 Betting By Board Employees
1320.140 Sale of Products by Board Appointees (Repealed)
1320.150 Humane Treatment of Horses (Repealed)

AUTHORITY: Authorized by Section 9(b) of the Illinois Horse Racing Act of 1975 [230 ILCS 5/9(b)].

SOURCE: Published in Rules and Regulations of Harness Racing (original date not cited in publication); codified at 5 Ill. Reg. 10948; amended at 9 Ill. Reg. 11653, effective July 15, 1985; amended at 18 Ill. Reg. 17751, effective November 28, 1994; amended at 20 Ill. Reg. 5883, effective April 15, 1996; amended at 31 Ill. Reg. _____, effective _____.

Section 1320.150 Humane Treatment of Horses (Repealed)

~~a) No person shall subject any animal to any form of cruelty, mistreatment, neglect, abuse, abandonment, or injury on the grounds of an organization licensee.~~

~~b) No person shall deprive any animal of necessary care, sustenance, shelter or~~

ILLINOIS RACING BOARD

NOTICE OF PROPOSED AMENDMENT

~~veterinary care on the grounds of an organization licensee.~~

(Source: Repealed at 31 Ill. Reg. _____, effective _____)

ILLINOIS RACING BOARD

NOTICE OF PROPOSED AMENDMENT

1) Heading of the Part: Security and Admissions

2) Code Citation: 11 Ill. Adm. Code 1325

3) Section Number: 1325.160 Proposed Action: Amend

4) Statutory Authority: 230 ILCS 5/9(b)

5) A Complete Description of the Subjects and Issues Involved: The proposed rulemaking expands the current turnstile rule to include electronic scanning devices at admission plazas.

6) Published studies or reports and sources of underlying data used to compose this rulemaking: None

7) Will this rulemaking replace any emergency rulemaking currently in effect? No

8) Does this rulemaking contain an automatic repeal date? No

9) Does this rulemaking contain incorporations by reference? No

10) Are there any other proposed rulemakings pending on this Part? No

11) Statement of Statewide Policy Objectives: No local governmental units will be required to increase expenditures.

12) Time, Place and Manner in which interested persons may comment on this proposed rulemaking: Written comments should be submitted, within 45 days after this Notice, to:

Mickey Ezzo
Illinois Racing Board
100 West Randolph
Suite 7-701
Chicago, Illinois 60601

312/814-5017

13) Initial Regulatory Flexibility Analysis:

ILLINOIS RACING BOARD

NOTICE OF PROPOSED AMENDMENT

A) Types of small businesses, small municipalities and not-for-profit corporations affected: None

B) Reporting, bookkeeping or other procedures required for compliance: None

C) Types of professional skills necessary for compliance: None

14) Regulatory Agenda which this rulemaking was summarized: This rulemaking was not included on either of the two most recent regulatory agendas because: the Board did not anticipate the need for this rulemaking at the time the agendas were published.

The full text of the Proposed Amendment begins on the next page.

ILLINOIS RACING BOARD

NOTICE OF PROPOSED AMENDMENT

TITLE 11: ALCOHOL, HORSE RACING, AND LOTTERY
SUBTITLE B: HORSE RACING
CHAPTER I: ILLINOIS RACING BOARD
SUBCHAPTER f: RULES AND REGULATIONS OF HARNESS RACING

PART 1325
SECURITY AND ADMISSIONS

Section

1325.10 Stable Enclosures Fenced
1325.20 Report of Arrival and Departure of Horses
1325.30 Stable Area Security
1325.40 Policing of Premises
1325.50 Admission to Parts of Premises
1325.60 Identification Cards and Badges
1325.70 Admission Statements
1325.80 State Admissions~~Admission~~ Tax
1325.90 Admissions Records
1325.100 Board Approval of Tickets and Credentials
1325.110 Credential~~Credentials~~ and Ticket Specimens
1325.120 Tax Exempt Credentials
1325.130 Tax Exempt Credentials Report (Repealed)
1325.140 Track Responsible for Credentials
1325.150 Board Access to Records
1325.160 Turnstiles and Electronic Scanning Devices
1325.170 Admission to Track
1325.180 Revocation of Credentials
1325.190 Inspections and Searches
1325.200 Investigative Authority

AUTHORITY: Authorized by Section 9(b) of the Illinois Horse Racing Act of 1975 [230 ILCS 5/9(b)].

SOURCE: Published in Rules and Regulations of Harness Racing, (original date not cited in publication); amended October 25, 1973, filed November 26, 1973; amended March 14, 1975, filed and effective March 27, 1975; amended May 9, 1975, filed May 15, 1975; amended at 4 Ill. Reg. 41, p. 164, effective September 26, 1980; codified at 5 Ill. Reg. 10955; amended at 14 Ill. Reg. 17665, effective October 16, 1990; amended at 15 Ill. Reg. 5748, effective April 4, 1991; amended at 31 Ill. Reg. _____, effective _____.

ILLINOIS RACING BOARD

NOTICE OF PROPOSED AMENDMENT

Section 1325.160 Turnstiles and Electronic Scanning Devices

All gates for the admission of patrons shall have turnstiles equipped with meters or electronic scanning devices, and the~~such~~ turnstiles or electronic scanning devices must be numbered consecutively or have other means of individual identification. The race track operator shall test the ~~turnstile~~ equipment at the opening of each racing day. The~~Said~~ test is to be made under the supervision and direction of the Board or such agents as the Board may appoint. A daily ~~turnstile~~ reconciliation is to show a beginning reading and final reading of each device~~turnstile~~, the total admitted, and also a classified breakdown of all types of admittance. The operator must employ methods, subject to the approval of the Board, to record serial numbers and code letters or numbers each day a tax exempt ticket or credential is used for admittance, in order to substantiate all tax exempt admissions.

(Source: Amended at 31 Ill. Reg. _____, effective _____)

ILLINOIS RACING BOARD

NOTICE OF PROPOSED AMENDMENTS

1) Heading of the Part: Officials of Meeting

2) Code Citation: 11 Ill. Adm. Code 1403

3)

Section Numbers:	Proposed Action:
1403.60	Repeal
1403.63	Repeal
1403.66	Repeal
1403.74	Repeal
1403.77	Repeal

4) Statutory Authority: 230 ILCS 5/9(b)

5) A Complete Description of the Subjects and Issues Involved: The proposed rulemaking repeals various Sections of Part 1403 as the first phase of the Board's efforts to consolidate the harness and thoroughbred rules. Proposed rules have been filed concurrently to establish a new Part 605 dedicated to horse health.

6) Published studies or reports and sources of underlying data used to compose this rulemaking: None

7) Will this rulemaking replace any emergency rulemaking currently in effect? No

8) Does this rulemaking contain an automatic repeal date? No

9) Does this rulemaking contain incorporations by reference? No

10) Are there any other proposed rulemakings pending on this Part? No

11) Statement of Statewide Policy Objectives: No local governmental units will be required to increase expenditures.

12) Time, Place and Manner in which interested persons may comment on this proposed rulemaking: Written comments should be submitted, within 45 days after this Notice, to:

Mickey Ezzo
Illinois Racing Board
100 West Randolph
Suite 7-701

ILLINOIS RACING BOARD

NOTICE OF PROPOSED AMENDMENTS

Chicago, Illinois 60601

312/814-5017

13) Initial Regulatory Flexibility Analysis:

A) Types of small businesses, small municipalities and not-for-profit corporations affected: None

B) Reporting, bookkeeping or other procedures required for compliance: None

C) Types of professional skills necessary for compliance: None

14) Regulatory Agenda which this rulemaking was summarized: This rulemaking was not included on either of the two most recent regulatory agendas because: the Board did not anticipate the need for this rulemaking at the time the agendas were published.

The full text of the Proposed Amendments begins on the next page:

ILLINOIS RACING BOARD

NOTICE OF PROPOSED AMENDMENTS

TITLE 11: ALCOHOL, HORSE RACING, AND LOTTERY
SUBTITLE B: HORSE RACING
CHAPTER I: ILLINOIS RACING BOARD
SUBCHAPTER g: RULES AND REGULATIONS OF HORSE RACING (THOROUGHBRED)

PART 1403
OFFICIALS OF MEETING

Section

1403.10 Designation of Officials
1403.20 Wagering Prohibited
1403.30 Patrol Judges
1403.40 Leaving Employment
1403.60 State Veterinarians Report Examinations (Repealed)
1403.63 Veterinarians' List (Repealed)
1403.66 Reports at Close of Meeting (Repealed)
1403.68 Dental Work on Horse (Repealed)
1403.70 Paddock Judge
1403.74 Inspection of Bandages (Repealed)
1403.77 Ice Bandages (Repealed)
1403.80 Jockey Room Custodian

AUTHORITY: Authorized by Section 9(b) of the Illinois Horse Racing Act of 1975 [230 ILCS 5/9(b)].

SOURCE: Published in Rules and Regulations of Horse Racing (original date not cited in publication); amended November 17, 1977, filed December 29, 1977; codified at 5 Ill. Reg. 10962; amended at 20 Ill. Reg. 13058, effective October 1, 1996; amended at 28 Ill. Reg. 11264, effective August 1, 2004; amended at 31 Ill. Reg. _____, effective _____.

Section 1403.60 State Veterinarians Report Examinations (Repealed)

~~The state veterinarians shall report to the state steward all examinations or inspections of any horse or premises under the jurisdiction of the Board.~~

(Source: Repealed at 31 Ill. Reg. _____, effective _____)

Section 1403.63 Veterinarians' List (Repealed)

~~The state veterinarian shall maintain a veterinarians' list and any horse placed on said list shall not be permitted to enter in a race until his name is removed from said list. Horses shall remain on said list at least five calendar days, unless in the opinion of the state veterinarians his name should be removed earlier from said list. A workout, at a distance specified by the state veterinarians, may be required prior to removing a horse from said list. The owner or trainer of a horse to be placed on the veterinarians' list for soreness or lameness by one of the state veterinarians may request a second opinion from the other official veterinarian. The official veterinarians shall then reach a mutual decision.~~

(Source: Repealed at 31 Ill. Reg. _____, effective _____)

Section 1403.66 Reports at Close of Meeting (Repealed)

~~At the close of each meeting, the state veterinarians shall make a written report to the Board of the conditions of the meeting and any recommendations they deem advisable.~~

(Source: Repealed at 31 Ill. Reg. _____, effective _____)

Section 1403.74 Inspection of Bandages (Repealed)

~~The paddock judge or paddock veterinarian shall inspect bandages just prior to the participation in a race of the horse on which they are used. They may order their removal and replacement if they see fit to do so. Should there be any circumstances in their use that indicates fraud, it shall be reported to the stewards, who after an investigation, shall report all the facts to the Board for such action as it deems appropriate.~~

(Source: Repealed at 31 Ill. Reg. _____, effective _____)

Section 1403.77 Ice Bandages (Repealed)

~~Cold water bandages, ice-boots, or bandages of that nature must be removed when a horse enters the paddock for a race and such equipment may not be used for racing purposes.~~

(Source: Repealed at 31 Ill. Reg. _____, effective _____)

ILLINOIS RACING BOARD

NOTICE OF PROPOSED AMENDMENTS

1) Heading of the Part: Trainers and Owners

2) Code Citation: 11 Ill. Adm. Code 1410

3)

Section Numbers:	Proposed Action:
1410.20	Repeal
1410.25	Repeal
1410.40	Repeal
1410.50	Repeal
1410.60	Repeal

4) Statutory Authority: 230 ILCS 5/9(b)

5) A Complete Description of the Subjects and Issues Involved: The proposed rulemaking repeals various Sections of Part 1410 as the first phase of the Board's efforts to consolidate the harness and thoroughbred rules. Proposed rules have been filed concurrently to establish a new Part 605 dedicated to horse health.

6) Published studies or reports and sources of underlying data used to compose this rulemaking: None

7) Will this rulemaking replace any emergency rulemaking currently in effect? No

8) Does this rulemaking contain an automatic repeal date? No

9) Does this rulemaking contain incorporations by reference? No

10) Are there any other proposed rulemakings pending on this Part? No

11) Statement of Statewide Policy Objectives: No local governmental units will be required to increase expenditures.

12) Time, Place and Manner in which interested persons may comment on this proposed rulemaking: Written comments should be submitted, within 45 days after this Notice, to:

Mickey Ezzo
Illinois Racing Board
100 West Randolph
Suite 7-701

ILLINOIS RACING BOARD

NOTICE OF PROPOSED AMENDMENTS

Chicago, Illinois 60601

312/814-5017

13) Initial Regulatory Flexibility Analysis:

A) Types of small businesses, small municipalities and not-for-profit corporations affected: None

B) Reporting, bookkeeping or other procedures required for compliance: None

C) Types of professional skills necessary for compliance: None

14) Regulatory Agenda which this rulemaking was summarized: This rulemaking was not included on either of the two most recent regulatory agendas because: the Board did not anticipate the need for this rulemaking at the time the agendas were published.

The full text of the Proposed Amendments begins on the next page.

ILLINOIS RACING BOARD

NOTICE OF PROPOSED AMENDMENTS

TITLE 11: ALCOHOL, HORSE RACING, AND LOTTERY
SUBTITLE B: HORSE RACING
CHAPTER I: ILLINOIS RACING BOARD
SUBCHAPTER g: RULES AND REGULATIONS OF HORSE RACING (THOROUGHBRED)

PART 1410
TRAINERS AND OWNERS

Section

1410.10 Absence of Trainers
1410.15 Deadline on Absence (Repealed)
1410.20 Report Disabled Horses (Repealed)
1410.25 Deceased or Sick Horses (Repealed)
1410.30 Horses Entered in the Daily Double (Repealed)
1410.40 State Veterinarians' List (Repealed)
1410.50 Obey Sanitary, Humane and Safety Laws (Repealed)
1410.55 Halters
1410.60 Report Deaths of Horses (Repealed)
1410.65 Fillies and Mares Bred
1410.70 Trainer Responsibility
1410.80 Employment of Veterinarians
1410.90 Harboring Unauthorized Persons
1410.95 Harboring of Drug Addicts
1410.100 Workout After Finish
1410.110 Addition to Owner-Trainer Rules
1410.115 Ownership of Horses

AUTHORITY: Authorized by Section 9(b) of the Illinois Horse Racing Act of 1975 [230 ILCS 5/9(b)].

SOURCE: Published in Rules and Regulations of Horse Racing (original date not cited in publication); amended October 17, 1975, filed October 21, 1975; codified at 5 Ill. Reg. 10975; amended at 6 Ill. Reg. 10014, effective August 3, 1982; amended at 13 Ill. Reg. 1846, effective January 25, 1989; amended at 31 Ill. Reg. _____, effective _____.

Section 1410.20 Report Disabled Horses (Repealed)

~~A trainer shall report all sickness or disability of his horses to the state veterinarians.~~

(Source: Repealed at 31 Ill. Reg. _____, effective _____)

Section 1410.25 Deceased or Sick Horses (Repealed)

~~No deceased or sick horse may be removed from the grounds of a licensed race track operator without prior approval of the state veterinarian's office.~~

(Source: Repealed at 31 Ill. Reg. _____, effective _____)

Section 1410.40 State Veterinarians' List (Repealed)

~~A horse excused through sickness or disability shall be placed on the state veterinarians' list.~~

(Source: Repealed at 31 Ill. Reg. _____, effective _____)

Section 1410.50 Obey Sanitary, Humane and Safety Laws (Repealed)

~~A trainer shall see to it that the stables and immediate surrounding area assigned to him are sanitary at all times and that the humane laws of the State of Illinois be observed, also that the fire prevention rules (especially no-smoking in the stable areas) be strictly observed at all times. Constant misuse of property will be considered when stall assignments are made.~~

(Source: Repealed at 31 Ill. Reg. _____, effective _____)

Section 1410.60 Report Deaths of Horses (Repealed)

~~A trainer shall report the death of any horse to the state veterinarians at once. Castrations and other operations shall be reported to the state veterinarians at once.~~

(Source: Repealed at 31 Ill. Reg. _____, effective _____)

ILLINOIS RACING BOARD

NOTICE OF PROPOSED AMENDMENT

1) Heading of the Part: Regulations for Meetings (Thoroughbred)

2) Code Citation: 11 Ill. Adm. Code 1424

3) Section Number: 1424.55 — Proposed Action: Repeal

4) Statutory Authority: 230 ILCS 5/9(b)

5) A Complete Description of the Subjects and Issues Involved: The proposed rulemaking repeals Section 1424.55 as the first phase of the Board's efforts to consolidate the harness and thoroughbred rules. Proposed rules have been filed concurrently to establish a new Part 605 dedicated to horse health.

6) Published studies or reports and sources of underlying data used to compose this rulemaking: None

7) Will this rulemaking replace any emergency rulemaking currently in effect? No

8) Does this rulemaking contain an automatic repeal date? No

9) Does this rulemaking contain incorporations by reference? No

10) Are there any other proposed rulemakings pending on this Part? No

11) Statement of Statewide Policy Objectives: No local governmental units will be required to increase expenditures.

12) Time, Place and Manner in which interested persons may comment on this proposed rulemaking: Written comments should be submitted, within 45 days after this Notice, to:

Mickey Ezzo
Illinois Racing Board
100 West Randolph
Suite 7-701
Chicago, Illinois 60601

312/814-5017

ILLINOIS RACING BOARD

NOTICE OF PROPOSED AMENDMENT

13) Initial Regulatory Flexibility Analysis:

A) Types of small businesses, small municipalities and not-for-profit corporations affected: None

B) Reporting, bookkeeping or other procedures required for compliance: None

C) Types of professional skills necessary for compliance: None

14) Regulatory Agenda which this rulemaking was summarized: This rulemaking was not included on either of the two most recent regulatory agendas because: the Board did not anticipate the need for this rulemaking at the time the agendas were published.

The full text of the Proposed Amendment begins on the next page.

ILLINOIS RACING BOARD

NOTICE OF PROPOSED AMENDMENT

TITLE 11: ALCOHOL, HORSE RACING, AND LOTTERY
SUBTITLE B: HORSE RACING
CHAPTER I: ILLINOIS RACING BOARD
SUBCHAPTER g: RULES AND REGULATIONS OF HORSE RACING (THOROUGHBRED)

PART 1424
REGULATIONS FOR MEETINGS
(THOROUGHBRED)

Section
1424.10 Illinois Racing Board Right of Entry
1424.20 Office for Racing Board
1424.25 Moving Offices (Repealed)
1424.40 Inspections and Searches
1424.45 Investigative Authority
1424.50 Allocation of Stalls
1424.55 AGID (Coggins) Test (Repealed)
1424.60 Distance Poles
1424.70 Arrivals, Departures and Stabling
1424.80 Departure Slips
1424.90 Horse Ambulance
1424.100 Races Per Day (Repealed)
1424.110 Extra Races
1424.120 Clockers
1424.125 Outriders
1424.140 Safety Rails
1424.150 Backstretch Paging System
1424.160 Camera
1424.170 Emergency Medical Services
1424.175 Manned Ambulance (Repealed)
1424.180 Policing of Premises
1424.190 Stable Area Security
1424.200 Stable Area Security
1424.210 Security Reports
1424.220 Night Patrol
1424.230 Telephones
1424.240 Calls Through Switchboard (Repealed)
1424.250 Races for Illinois Horses
1424.260 Breeder Awards

ILLINOIS RACING BOARD

NOTICE OF PROPOSED AMENDMENT

1424.270 Admission to Parts of Premises
1424.280 Stable Areas Fenced
1424.290 Merchandise Selling
1424.300 Tip Sheets
1424.310 Alcoholic Beverages
1424.320 Jockey Quarters
1424.330 Water Supply and Washrooms
1424.340 Drug Vendors
1424.350 Seven Day Rule
1424.353 Penalty for Violation of Rules
1424.355 Stall Availability Prior to Meet
1424.360 Notification of Change

AUTHORITY: Authorized by Section 9(b) of the Illinois Horse Racing Act of 1975 [230 ILCS 5/9(b)].

SOURCE: Published in Rules and Regulations of Horse Racing (original date not cited in publication); added October 25, 1973, filed November 26, 1973; added August 8, 1973; amended February 15, 1974, filed February 28, 1974; amended April 11, 1974, filed April 30, 1974; amended July 12, 1974, filed July 22, 1974; amended October 25, 1974, filed November 7, 1974; amended March 14, 1975, filed and effective March 27, 1975; amended May 9, 1975, filed May 15, 1975; amended June 19, 1976, filed June 25, 1976; amended December 9, 1977, filed December 29, 1977; amended at 4 Ill. Reg. 41, p. 164, effective September 26, 1980; codified at 5 Ill. Reg. 10996; amended at 8 Ill. Reg. 12460, effective June 27, 1984; amended at 9 Ill. Reg. 9166, effective May 30, 1985; amended at 14 Ill. Reg. 20545, effective December 7, 1990; amended at 16 Ill. Reg. 7493, effective April 24, 1992; amended at 16 Ill. Reg. 11193, effective June 25, 1992; amended at 17 Ill. Reg. 3038, effective February 23, 1993; emergency amendment at 23 Ill. Reg. 7779, effective June 28, 1999, for a maximum of 150 days; amended at 23 Ill. Reg. 13943, effective November 2, 1999; amended at 28 Ill. Reg. 6605, effective April 19, 2004; amended at 31 Ill. Reg. _____, effective _____.

Section 1424.55 AGID (Coggins) Test (Repealed)

~~Horses racing in Illinois must have a negative Agar-Gel immuno-diffusion test (Coggins) test done at least once every twelve months. A current negative test certificate from a laboratory, approved by the U.S. Department of Agriculture, must be on file with the Racing Secretary. Trainers that start a horse without a current negative test certificate on file with the Racing Secretary may be fined. The state veterinarian may draw blood from any horse on the grounds for the purpose of conducting the Agar-Gel immuno-diffusion (Coggins) test.~~

ILLINOIS RACING BOARD

NOTICE OF PROPOSED AMENDMENT

(Source: Repealed at 31 Ill. Reg. _____, effective _____)

ILLINOIS RACING BOARD

NOTICE OF PROPOSED AMENDMENT

1) Heading of the Part: Admissions and Credentials

2) Code Citation: 11 Ill. Adm. Code 1428

3) Section Number: 1428.200 Proposed Action: Amend

4) Statutory Authority: 230 ILCS 5/9(b)

5) A Complete Description of the Subjects and Issues Involved: The proposed rulemaking expands the current turnstile rule to include electronic scanning devices at admission plazas.

6) Published studies or reports and sources of underlying data used to compose this rulemaking: None

7) Will this rulemaking replace any emergency rulemaking currently in effect? No

8) Does this rulemaking contain an automatic repeal date? No

9) Does this rulemaking contain incorporations by reference? No

10) Are there any other proposed rulemakings pending on this Part? No

11) Statement of Statewide Policy Objectives: No local governmental units will be required to increase expenditures.

12) Time, Place and Manner in which interested persons may comment on this proposed rulemaking: Written comments should be submitted, within 45 days after this Notice, to:

Mickey Ezzo
Illinois Racing Board
100 West Randolph
Suite 7-701
Chicago, Illinois 60601

312/814-5017

13) Initial Regulatory Flexibility Analysis:

ILLINOIS RACING BOARD

NOTICE OF PROPOSED AMENDMENT

A) Types of small businesses, small municipalities and not-for-profit corporations affected: None

B) Reporting, bookkeeping or other procedures required for compliance: None

C) Types of professional skills necessary for compliance: None

14) Regulatory Agenda which this rulemaking was summarized: This rulemaking was not included on either of the two most recent regulatory agendas because: the Board did not anticipate the need for this rulemaking at the time the agendas were published.

The full text of the Proposed Amendment begins on the next page.

ILLINOIS RACING BOARD

NOTICE OF PROPOSED AMENDMENT

TITLE 11: ALCOHOL, HORSE RACING, AND LOTTERY
SUBTITLE B: HORSE RACING
CHAPTER I: ILLINOIS RACING BOARD
SUBCHAPTER g: RULES AND REGULATIONS OF HORSE RACING (THOROUGHBRED)

PART 1428
ADMISSIONS AND CREDENTIALS

Section

1428.10 State Admissions Tax
1428.20 Admission Records
1428.30 Weekly Remittance of Tax
1428.40 Admission Statements
1428.50 Delivery of Reports
1428.60 Board Approval of Tickets and Credentials
1428.70 Control Numbers
1428.80 Revocation of Tickets, Credentials
1428.90 Notice of State Tax
1428.100 Credential and Ticket Specimens
1428.110 Gate Cards
1428.120 Tax Exempt Credentials
1428.130 Report on Tax Exempt Credentials (Repealed)
1428.140 Concessionaires, Employees Credentials
1428.150 Requisitions for Passes
1428.160 Tax Exempt Credentials Report (Repealed)
1428.170 Summary of Tickets and Credentials
1428.180 Track Responsible for Credentials
1428.190 Board Access to Records
1428.200 Turnstiles and Electronic Scanning Devices
1428.210 Admission to Track
1428.220 Revocation of Credentials
1428.230 Admissions for Licensees
1428.240 Intertrack Wagering Location Licensee Admission Fees

AUTHORITY: Authorized by Section 9(b) of the Illinois Horse Racing Act of 1975 [230 ILCS 5/9(b)].

ILLINOIS RACING BOARD

NOTICE OF PROPOSED AMENDMENT

SOURCE: Published in Rules and Regulations of Horse Racing (original date not cited in publication); amended March 14, 1975, filed and effective March 27, 1975; codified at 5 Ill. Reg. 11002; amended at 14 Ill. Reg. 17633, effective October 16, 1990; amended at 14 Ill. Reg. 20042, effective December 4, 1990; emergency amendment at 17 Ill. Reg. 3683, effective March 4, 1993, for a maximum of 150 days; amended at 17 Ill. Reg. 14049, effective August 16, 1993; amended at 19 Ill. Reg. 17187, effective January 1, 1996; amended at 31 Ill. Reg. _____, effective _____.

Section 1428.200 Turnstiles and Electronic Scanning Devices

All gates for the admission of patrons shall have turnstiles equipped with meters or electronic scanning devices, and the~~such~~ turnstiles or electronic scanning devices must be numbered consecutively or have other means of individual identification. The race track operator shall test the ~~turnstile~~ equipment at the opening of each racing day. The~~Said~~ test is to be made under the supervision and direction of the Board or such agents as the Board may appoint. A daily ~~turnstile~~ reconciliation is to show a beginning reading and final reading of each device~~turnstile~~, the total admitted, and also a classified breakdown of all types of admittance. The operator must employ methods, subject to the approval of the Board, to record serial numbers and code letters or numbers each day a tax exempt ticket or credential is used for admittance, in order to substantiate all tax exempt admissions.

(Source: Amended at 31 Ill. Reg. _____, effective _____)

DEPARTMENT OF HUMAN SERVICES

NOTICE OF ADOPTED AMENDMENTS

1) Heading of the Part: Aid to the Aged, Blind or Disabled

2) Code Citation: 89 Ill. Adm. Code 113

3)

Section Numbers:	Adopted Action:
113.160	Amendment
113.253	Amendment
113.260	Amendment

4) Statutory Authority: Implementing Article III and authorized by Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/Art. III and 12-13]

5) Effective Date of Amendments: July 19, 2007

6) Does this rulemaking contain an automatic repeal date? No

7) Does this rulemaking contain incorporations by reference? No

8) A copy of the adopted amendments, including any material incorporated by reference, is on file in the agency's principal office and is available for public inspection.

9) Notice of Proposal Published in the Illinois Register: 31 Ill. Reg. 2713; February 16, 2007

10) Has JCAR issued a Statement of Objection to this rulemaking? No

11) Differences between proposal and final version: No substantive changes were made in the text of the adopted amendments.

12) Have all changes agreed upon by the agency and JCAR been made as indicated in the agreements issued by JCAR? Yes

13) Will these amendments replace any emergency amendments currently in effect? No

14) Are there any amendments pending on this Part? No

15) Summary and purpose of rulemaking: This rulemaking affects Human Capital Development. A grant adjustment is an allowance for the Aged, Blind or Disabled cases that ensures that the amount of the Supplemental Security Income (SSI) increase from

DEPARTMENT OF HUMAN SERVICES

NOTICE OF ADOPTED AMENDMENTS

July 1977 and later will be available to clients. To comply with federal regulations at 20 CFR 416.2096, this rulemaking increases the grant adjustment and sheltered care/personal or nursing care rate amounts by the amount of the increase in Social Security and SSI benefits. In order to maintain the benefit levels, these changes increase the AABD Grant Adjustment Allowance and Sheltered Care/Personal or Nursing Care rates by $20.00, the amount of the January 2007 SSA/SSI benefit increase.

16) Information and questions regarding these adopted amendments shall be directed to:

Tracie Drew, Chief
Bureau of Administrative Rules and Procedures
Department of Human Services
100 South Grand Avenue East
Harris Building, 3rd Floor
Springfield, Illinois 62762

217/785-9772

The full text of the Adopted Amendments begin on the next page:

DEPARTMENT OF HUMAN SERVICES

NOTICE OF ADOPTED AMENDMENTS

TITLE 89: SOCIAL SERVICES
CHAPTER IV: DEPARTMENT OF HUMAN SERVICES
SUBCHAPTER b: ASSISTANCE PROGRAMS

PART 113
AID TO THE AGED, BLIND OR DISABLED

SUBPART A: GENERAL PROVISIONS

Section
113.1 Description of the Assistance Program
113.5 Incorporation By Reference

SUBPART B: NON-FINANCIAL FACTORS OF ELIGIBILITY

Section
113.9 Client Cooperation
113.10 Citizenship
113.20 Residence
113.30 Age
113.40 Blind
113.50 Disabled
113.60 Living Arrangement
113.70 Institutional Status
113.80 Social Security Number

SUBPART C: FINANCIAL FACTORS OF ELIGIBILITY

Section
113.100 Unearned Income
113.101 Budgeting Unearned Income
113.102 Budgeting Unearned Income of Applicants Receiving Income on Date of Application And/Or Date of Decision
113.103 Initial Receipt of Unearned Income
113.104 Termination of Unearned Income
113.105 Unearned Income In-Kind
113.106 Earmarked Income
113.107 Lump Sum Payments and Income Tax Refunds
113.108 Protected Income (Repealed)

DEPARTMENT OF HUMAN SERVICES

NOTICE OF ADOPTED AMENDMENTS

113.109 Earned Income (Repealed)
113.110 Budgeting Earned Income (Repealed)
113.111 Protected Income
113.112 Earned Income
113.113 Exempt Unearned Income
113.114 Budgeting Earned Income of Applicants Receiving Income On Date of Application And/Or Date of Decision
113.115 Initial Employment
113.116 Budgeting Earned Income For Contractual Employees
113.117 Budgeting Earned Income For Non-contractual School Employees
113.118 Termination of Employment
113.120 Exempt Earned Income
113.125 Recognized Employment Expenses
113.130 Income From Work/Study/Training Programs
113.131 Earned Income From Self-Employment
113.132 Earned Income From Roomer and Boarder
113.133 Earned Income From Rental Property
113.134 Earned Income In-Kind
113.139 Payments from the Illinois Department of Children and Family Services
113.140 Assets
113.141 Exempt Assets
113.142 Asset Disregard
113.143 Deferral of Consideration of Assets
113.154 Property Transfers For Applications Filed Prior To October 1, 1989 (Repealed)
113.155 Property Transfers For Applications Filed On Or After October 1, 1989 (Repealed)
113.156 Court Ordered Child Support Payments of Parent/Step-Parent
113.157 Responsibility of Sponsors of Non-citizens Entering the Country Prior to 8/22/96
113.158 Responsibility of Sponsors of Non-citizens Entering the Country On or After 08/22/96
113.160 Assignment of Medical Support Rights

SUBPART D: PAYMENT AMOUNTS

Section
113.245 Payment Levels for AABD
113.246 Personal Allowance
113.247 Personal Allowance Amounts
113.248 Shelter

DEPARTMENT OF HUMAN SERVICES

NOTICE OF ADOPTED AMENDMENTS

113.249 Utilities and Heating Fuel
113.250 Laundry
113.251 Telephone
113.252 Transportation, Lunches, Special Fees
113.253 Allowances for Increase in SSI Benefits
113.254 Nursing Care or Personal Care in Home Not Subject to Licensing
113.255 Sheltered Care/Personal or Nursing Care in a Licensed Group Care Facility
113.256 Shopping Allowance
113.257 Special Allowances for Blind and Partially Sighted (Blind Only)
113.258 Home Delivered Meals
113.259 AABD Fuel and Utility Allowances By Area
113.260 Sheltered Care, Personal Care or Nursing Care Rates
113.261 Cases in Licensed Intermediate Care Facilities, Licensed Skilled Nursing Facilities, DMHDD Facilities and All Other Licensed Medical Facilities
113.262 Meeting the Needs of an Ineligible Dependent with Client's Income
113.263 Service Animals
113.264 Refugees Ineligible for SSI

SUBPART E: OTHER PROVISIONS

Section
113.300 Persons Who May Be Included In the Assistance Unit
113.301 Grandfathered Cases
113.302 Interim Assistance (Repealed)
113.303 Special Needs Authorizations
113.304 Retrospective Budgeting
113.305 Budgeting Schedule
113.306 Purchase and Repair of Household Furniture (Repealed)
113.307 Property Repairs and Maintenance
113.308 Excess Shelter Allowance
113.309 Limitation on Amount of AABD Assistance to Recipients from Other States (Repealed)
113.320 Redetermination of Eligibility
113.330 Attorney's Fees for VA Appellants (Repealed)

SUBPART F: INTERIM ASSISTANCE

Section
113.400 Description of the Interim Assistance Program

DEPARTMENT OF HUMAN SERVICES

NOTICE OF ADOPTED AMENDMENTS

113.405	Pending SSI Application (Repealed)
113.410	More Likely Than Not Eligible for SSI (Repealed)
113.415	Non-Financial Factors of Eligibility (Repealed)
113.420	Financial Factors of Eligibility (Repealed)
113.425	Payment Levels for Chicago Interim Assistance Cases (Repealed)
113.430	Payment Levels for all Interim Assistance Cases Outside Chicago (Repealed)
113.435	Medical Eligibility (Repealed)
113.440	Attorney's Fees for SSI Applicants (Repealed)
113.445	Advocacy Program for Persons Receiving Interim Assistance (Repealed)
113.450	Limitation on Amount of Interim Assistance to Recipients from Other States (Repealed)
113.500	Attorney's Fees for SSI Appellants (Renumbered)

AUTHORITY: Implementing Article III and authorized by Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/Art. III and 12-13].

SOURCE: Filed effective December 30, 1977; peremptory amendment at 2 Ill. Reg. 17, p. 117, effective February 1, 1978; amended at 2 Ill. Reg. 31, p. 134, effective August 5, 1978; emergency amendment at 2 Ill. Reg. 37, p. 4, effective August 30, 1978, for a maximum of 150 days; emergency expired January 28, 1979; peremptory amendment at 2 Ill. Reg. 46, p. 44, effective November 1, 1978; emergency amendment at 3 Ill. Reg. 16, p. 41, effective April 9, 1979, for a maximum of 150 days; emergency amendment at 3 Ill. Reg. 28, p. 182, effective July 1, 1979, for a maximum of 150 days; amended at 3 Ill. Reg. 33, p. 399, effective August 18, 1979; amendment at 3 Ill. Reg. 33, p. 415, effective August 18, 1979; amended at 3 Ill. Reg. 38, p. 243, effective September 21, 1979; peremptory amendment at 3 Ill. Reg. 38, p. 321, effective September 7, 1979; amended at 3 Ill. Reg. 40, p. 140, effective October 6, 1979; amended at 3 Ill. Reg. 46, p. 36, effective November 2, 1979; amended at 3 Ill. Reg. 47, p. 96, effective November 13, 1979; amended at 3 Ill. Reg. 48, p. 1, effective November 15, 1979; peremptory amendment at 4 Ill. Reg. 9, p. 259, effective February 22, 1980; amended at 4 Ill. Reg. 10, p. 258, effective February 25, 1980; at 4 Ill. Reg. 12, p. 551, effective March 10, 1980; amended at 4 Ill. Reg. 27, p. 387, effective June 24, 1980; emergency amendment at 4 Ill. Reg. 29, p. 294, effective July 8, 1980, for a maximum of 150 days; amended at 4 Ill. Reg. 37, p. 797, effective September 2, 1980; amended at 4 Ill. Reg. 37, p. 800, effective September 2, 1980; amended at 4 Ill. Reg. 45, p. 134, effective October 27, 1980; amended at 5 Ill. Reg. 766, effective January 2, 1981; amended at 5 Ill. Reg. 1134, effective January 26, 1981; peremptory amendment at 5 Ill. Reg. 5722, effective June 1, 1981; amended at 5 Ill. Reg. 7071, effective June 23, 1981; amended at 5 Ill. Reg. 7104, effective June 23, 1981; amended at 5 Ill. Reg. 8041, effective July 27, 1981; amended at 5 Ill. Reg. 8052, effective July 24, 1981; peremptory amendment at 5 Ill. Reg. 8106, effective August 1, 1981; peremptory amendment at 5 Ill. Reg. 10062, effective

DEPARTMENT OF HUMAN SERVICES

NOTICE OF ADOPTED AMENDMENTS

October 1, 1981; peremptory amendment at 5 Ill. Reg. 10079, effective October 1, 1981; peremptory amendment at 5 Ill. Reg. 10095, effective October 1, 1981; peremptory amendment at 5 Ill. Reg. 10113, effective October 1, 1981; peremptory amendment at 5 Ill. Reg. 10124, effective October 1, 1981; peremptory amendment at 5 Ill. Reg. 10131, effective October 1, 1981; amended at 5 Ill. Reg. 10730, effective October 1, 1981; amended at 5 Ill. Reg. 10733, effective October 1, 1981; amended at 5 Ill. Reg. 10760, effective October 1, 1981; amended at 5 Ill. Reg. 10767, effective October 1, 1981; peremptory amendment at 5 Ill. Reg. 11647, effective October 16, 1981; peremptory amendment at 6 Ill. Reg. 611, effective January 1, 1982; amended at 6 Ill. Reg. 1216, effective January 14, 1982; emergency amendment at 6 Ill. Reg. 2447, effective March 1, 1982, for a maximum of 150 days; peremptory amendment at 6 Ill. Reg. 2452, effective February 11, 1982; peremptory amendment at 6 Ill. Reg. 6475, effective May 18, 1982; peremptory amendment at 6 Ill. Reg. 6912, effective May 20, 1982; emergency amendment at 6 Ill. Reg. 7299, effective June 2, 1982, for a maximum of 150 days; amended at 6 Ill. Reg. 8115, effective July 1, 1982; amended at 6 Ill. Reg. 8142, effective July 1, 1982; amended at 6 Ill. Reg. 8159, effective July 1, 1982; amended at 6 Ill. Reg. 10970, effective August 26, 1982; amended at 6 Ill. Reg. 11921, effective September 21, 1982; amended at 6 Ill. Reg. 12293, effective October 1, 1982; amended at 6 Ill. Reg. 12318, effective October 1, 1982; amended at 6 Ill. Reg. 13754, effective November 1, 1982; rules repealed, new rules adopted and codified at 7 Ill. Reg. 907, effective January 10, 1983; amended (by adding Sections being codified with no substantive change) at 7 Ill. Reg. 5195; amended at 7 Ill. Reg. 9367, effective August 1, l983; amended at 7 Ill. Reg. 17351, effective December 21, 1983; amended at 8 Ill. Reg. 537, effective December 30, 1983; amended at 8 Ill. Reg. 5225, effective April 9, l984; amended at 8 Ill. Reg. 6746, effective April 27, 1984; amended at 8 Ill. Reg. 11414, effective June 27, l984; amended at 8 Ill. Reg. 13273, effective July 16, l984; amended (by Sections being codified with no substantive change) at 8 Ill. Reg. 17895; amended at 8 Ill. Reg. 18896, effective September 26, 1984; amended at 9 Ill. Reg. 5335, effective April 5, 1985; amended at 9 Ill. Reg. 8166, effective May 17, 1985; amended at 9 Ill. Reg. 8657, effective May 25, 1985; amended at 9 Ill. Reg. 11302, effective July 5, 1985; amended at 9 Ill. Reg. 11636, effective July 8, 1985; amended at 9 Ill. Reg. 11991, effective July 12, 1985; amended at 9 Ill. Reg. 12806, effective August 9, 1985; amended at 9 Ill. Reg. 15896, effective October 4, 1985; amended at 9 Ill. Reg. 16291, effective October 10, 1985; emergency amendment at 10 Ill. Reg. 364, effective January 1, 1986; amended at 10 Ill. Reg. 1183, effective January 10, 1986; amended at 10 Ill. Reg. 6956, effective April 16, 1986; amended at 10 Ill. Reg. 8794, effective May 12, 1986; amended at 10 Ill. Reg. 10628, effective June 3, 1986; amended at 10 Ill. Reg. 11920, effective July 3, 1986; amended at 10 Ill. Reg. 15110, effective September 5, 1986; amended at 10 Ill. Reg. 15631, effective September 19, 1986; amended at 11 Ill. Reg. 3150, effective February 6, 1987; amended at 11 Ill. Reg. 8712, effective April 20, 1987; amended at 11 Ill. Reg. 9919, effective May 15, 1987; emergency amendment at 11 Ill. Reg. 12441, effective July 10, 1987, for a maximum of 150 days; amended at 11 Ill. Reg. 20880, effective December 14, 1987; amended at 12 Ill. Reg. 867,

effective January 1, 1988; amended at 12 Ill. Reg. 2137, effective January 11, 1988; amended at 12 Ill. Reg. 3497, effective January 22, 1988; amended at 12 Ill. Reg. 5642, effective March 15, 1988; amended at 12 Ill. Reg. 6151, effective March 22, 1988; amended at 12 Ill. Reg. 7687, effective April 22, 1988; amended at 12 Ill. Reg. 8662, effective May 13, 1988; amended at 12 Ill. Reg. 9023, effective May 20, 1988; amended at 12 Ill. Reg. 9669, effective May 24, 1988; emergency amendment at 12 Ill. Reg. 11828, effective July 1, 1988, for a maximum of 150 days; amended at 12 Ill. Reg. 14162, effective August 30, 1988; amended at 12 Ill. Reg. 17849, effective October 25, 1988; amended at 13 Ill. Reg. 63, effective January 1, 1989; emergency amendment at 13 Ill. Reg. 3402, effective March 3, 1989, for a maximum of 150 days; amended at 13 Ill. Reg. 6007, effective April 14, 1989; amended at 13 Ill. Reg. 12553, effective July 12, 1989; amended at 13 Ill. Reg. 13609, effective August 11, 1989; emergency amendment at 13 Ill. Reg. 14467, effective September 1, 1989, for a maximum of 150 days; emergency amendment at 13 Ill. Reg. 16154, effective October 2, 1989, for a maximum of 150 days; emergency expired March 1, 1990; amended at 14 Ill. Reg. 720, effective January 1, 1990; amended at 14 Ill. Reg. 6321, effective April 16, 1990; amended at 14 Ill. Reg. 13187, effective August 6, 1990; amended at 14 Ill. Reg. 14806, effective September 3, 1990; amended at 14 Ill. Reg. 16957, effective September 30, 1990; amended at 15 Ill. Reg. 277, effective January 1, 1991; emergency amendment at 15 Ill. Reg. 1111, effective January 10, 1991, for a maximum of 150 days; amended at 15 Ill. Reg. 5291, effective April 1, 1991; amended at 15 Ill. Reg. 5698, effective April 10, 1991; amended at 15 Ill. Reg. 7104, effective April 30, 1991; amended at 15 Ill. Reg. 11142, effective July 22, 1991; amended at 15 Ill. Reg. 11948, effective August 12, 1991; amended at 15 Ill. Reg. 14073, effective September 11, 1991; emergency amendment at 15 Ill. Reg. 15119, effective October 7, 1991, for a maximum of 150 days; amended at 15 Ill. Reg. 16709, effective November 1, 1991; amended at 16 Ill. Reg. 3468, effective February 20, 1992; amended at 16 Ill. Reg. 9986, effective June 15, 1992; amended at 16 Ill. Reg. 11565, effective July 15, 1992; emergency amendment at 16 Ill. Reg. 13641, effective September 1, 1992, for a maximum of 150 days; emergency amendment at 16 Ill. Reg. 14722, effective September 15, 1992, for a maximum of 150 days; emergency amendment at 16 Ill. Reg. 17154, effective November 1, 1992, for a maximum of 150 days; emergency amendment at 16 Ill. Reg. 17764, effective November 13, 1992, for a maximum of 150 days; amended at 17 Ill. Reg. 827, effective January 15, 1993; amended at 17 Ill. Reg. 2263, effective February 15, 1993; amended at 17 Ill. Reg. 3202, effective February 26, 1993; amended at 17 Ill. Reg. 4322, effective March 22, 1993; amended at 17 Ill. Reg. 6804, effective April 21, 1993; amended at 17 Ill. Reg. 14612, effective August 26, 1993; amended at 18 Ill. Reg. 2018, effective January 21, 1994; amended at 18 Ill. Reg. 7759, effective May 5, 1994; amended at 18 Ill. Reg. 12818, effective August 5, 1994; amended at 19 Ill. Reg. 1052, effective January 26, 1995; amended at 19 Ill. Reg. 2875, effective February 24, 1995; amended at 19 Ill. Reg. 6639, effective May 5, 1995; emergency amendment at 19 Ill. Reg. 8409, effective June 9, 1995, for a maximum of 150 days; amended at 19 Ill. Reg. 15034, effective October 17, 1995; amended at 20 Ill. Reg. 858, effective December 29, 1995;

emergency amendment at 21 Ill. Reg. 673, effective January 1, 1997, for a maximum of a 150 days; amended at 21 Ill. Reg. 7404, effective May 31, 1997; recodified from the Department of Public Aid to the Department of Human Services at 21 Ill. Reg. 9322; amended at 22 Ill. Reg. 13642, effective July 15, 1998; emergency amendment at 22 Ill. Reg. 16348, effective September 1, 1998, for a maximum of 150 days; amended at 22 Ill. Reg. 18931, effective October 1, 1998; emergency amendment at 22 Ill. Reg. 21750, effective November 24, 1998, for a maximum of 150 days; emergency amendment at 23 Ill. Reg. 579, effective January 1, 1999, for a maximum of 150 days; amended at 23 Ill. Reg. 1607, effective January 20, 1999; amended at 23 Ill. Reg. 5548, effective April 23, 1999; amended at 23 Ill. Reg. 6052, effective May 4, 1999; amended at 23 Ill. Reg. 6425, effective May 15, 1999; amended at 23 Ill. Reg. 6935, effective May 30, 1999; amended at 23 Ill. Reg. 7887, effective June 30, 1999; emergency amendment at 23 Ill. Reg. 8650, effective July 13, 1999, for a maximum of 150 days; amended at 23 Ill. Reg. 10161, effective August 3, 1999; amended at 23 Ill. Reg. 13852, effective November 19, 1999; amended at 24 Ill. Reg. 2328, effective February 1, 2000; amended at 24 Ill. Reg. 11622, effective July 18, 2000; amended at 24 Ill. Reg. 13394, effective August 18, 2000; amended at 25 Ill. Reg. 5326, effective March 30, 2001; amended at 26 Ill. Reg. 179, effective January 1, 2002; amended at 26 Ill. Reg. 8532, effective May 31, 2002; amended at 26 Ill. Reg. 13521, effective September 3, 2002; amended at 27 Ill. Reg. 7252, effective April 7, 2003; amended at 28 Ill. Reg. 11139, effective July 21, 2004; emergency amendment at 28 Ill. Reg. 11366, effective July 21, 2004, for a maximum of 150 days; emergency amendment at 28 Ill. Reg. 12469, effective August 20, 2004, for a maximum of 150 days; emergency expired January 16, 2005; amended at 29 Ill. Reg. 648, effective December 16, 2004; amended at 29 Ill. Reg. 5703, effective April 11, 2005; amended at 29 Ill. Reg. 10176, effective July 5, 2005; amended at 30 Ill. Reg. 16065, effective September 21, 2006; amended at 31 Ill. Reg. 6981, effective April 30, 2007; amended at 31 Ill. Reg. 11306, effective July 19, 2007.

SUBPART C: FINANCIAL FACTORS OF ELIGIBILITY

Section 113.160 Assignment of Medical Support Rights

a) As a condition of eligibility for medical assistance under the AABD Program, each applicant or recipient by operation of State law, automatically assigns to the Department any rights to support which the applicant or recipient may have. This assignment gives the Department the right to collect support money directly from the absent spouse in order to be reimbursed for assistance given to the applicant/recipient.

b) As a condition of eligibility for medical assistance under the AABD Program each legally able applicant and recipient must cooperate (see 89 Ill. Adm. Code

120.320(b) with the Department in obtaining medical support or payments. Note: Cooperation in establishing paternity is not a requirement for medical assistance under the AABD Program.) ("Legally able" means the applicant/recipient has the legal authority to execute an assignment of medical support rights.)

c) Failure or Refusal to Cooperate in Obtaining Medical Support or Payments

1) If an applicant/recipient fails or refuses to cooperate with the Department in obtaining medical support or payments, he/she is ineligible for medical assistance and will be removed from the assistance unit for medical assistance. (Non-cooperation is failure/refusal to comply with the requirements (except "paternity") of 89 Ill. Adm. Code 120.320(b)). However, the applicant/recipient remains eligible for AABD cash benefits.

2) If the applicant/recipient fails/refuses to cooperate in obtaining medical support/payments (not applicable to "establishing paternity") or sign-up for no cost medical insurance, he/she is ineligible for medical assistance for as long as he/she continues to fail/refuse to cooperate. If the applicant/recipient later wishes to receive medical assistance, then he/she must cooperate by complying with the requirement (see 89 Ill. Adm. Code 120.320(b) that he/she previously failed/refused to meet.

3) An applicant/recipient can appeal the Department's determination that~~the~~ he/she failed/refused to cooperate in obtaining medical support payments or that he/she failed/refused to sign-up for no cost medical insurance. Such appeal shall be in accordance with 89 Ill. Adm. Code 14~~104~~: Subpart A.

d) The Department will provide or continue to provide medical assistance to any applicant or recipient who would otherwise be eligible for medical assistance but for the refusal by a person legally able to cooperate in securing medical support.

(Source: Amended at 31 Ill. Reg. 11306, effective July 19, 2007)

SUBPART D: PAYMENT AMOUNTS

Section 113.253 Allowances for Increase in SSI Benefits

a) An allowance for $444.90~~424.90~~ is authorized for all AABD cases as a "grant

adjustment". A grant adjustment is an allowance that ensures that the amount of the SSI increase from July 1977 and later will be available to clients.

b) EXCEPTIONS: For clients whose assistance payments include an allowance for Sheltered Care or Care Not Subject to Licensing a "grant adjustment" of $10 is authorized. Individuals residing in long term group care facilities do not receive any "grant adjustment".

(Source: Amended at 31 Ill. Reg. 11306, effective July 19, 2007)

Section 113.260 Sheltered Care, Personal Care or Nursing Care Rates

Group A Counties	Needs Assessment	Group B Counties
1020 ~~1000~~	0-7	1033~~1013~~
1025 ~~1005~~	8	1040~~1020~~
1031 ~~1011~~	9	1046~~1026~~
1036 ~~1016~~	10	1053~~1033~~
1042 ~~1022~~	11	1060~~1040~~
1047 ~~1027~~	12	1066~~1046~~
1053 ~~1033~~	13	1073~~1053~~
1058 ~~1038~~	14	1079~~1059~~

1064 ~~1044~~	15	1086~~1066~~
1069 ~~1049~~	16	1093~~1073~~
1075 ~~1055~~	17	1099~~1079~~
1080 ~~1060~~	18	1106~~1086~~
1086 ~~1066~~	19	1112~~1092~~
1091 ~~1071~~	20	1119~~1099~~
1097 ~~1077~~	21	1126~~1106~~
1102 ~~1082~~	22	1132~~1112~~
1108 ~~1088~~	23	1139~~1119~~
1113 ~~1093~~	24	1145~~1125~~

a) Group A Counties are counties other than Cook, DuPage, Kane, Lake and Will.

b) Group B Counties are Cook, DuPage, Kane, Lake and Will.

c) Rate includes shelter factor and approved activity and social rehabilitation programs.

(Source: Amended at 31 Ill. Reg. 11306, effective July 19, 2007)

DEPARTMENT OF HUMAN SERVICES

NOTICE OF ADOPTED AMENDMENT

1) Heading of the Part: Food Stamps

2) Code Citation: 89 Ill. Adm. Code 121

3)

Section Number:	Adopted Action:
121.63	Amendment

4) Statutory Authority: Implementing Sections 12-4.4 through 12-4.6 and authorized by Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/12-4.4 through 12-4.6 and 12-13]

5) Effective Date of Amendment: July 23, 2007

6) Does this rulemaking contain an automatic repeal date? No

7) Does this rulemaking contain incorporations by reference? No

8) A copy of the adopted amendment, including any material incorporated by reference, is on file in the agency's principal office and is available for public inspection.

9) Notice of Proposal Published in Illinois Register: 31 Ill. Reg. 1791; January 19, 2007

10) Has JCAR Issued a Statement of Objection to this rulemaking? No

11) Differences between proposal and final version: No substantive changes were made in the text of the proposed amendment.

12) Have all the changes agreed upon by the agency and JCAR been made as indicated in the agreements issued by JCAR? Yes

13) Will this amendment replace any emergency amendment currently in effect? No

14) Are there any amendments pending on this Part? Yes

Section Numbers:	Proposed Action:	Illinois Register Citation:
121.23	Amendment	31 Ill. Reg. 10446; July 20, 2007
121.24	Amendment	31 Ill. Reg. 10446, July 20, 2007
121.26	Amendment	31 Ill. Reg. 10446, July 20, 2007

DEPARTMENT OF HUMAN SERVICES

NOTICE OF ADOPTED AMENDMENT

15) Summary and Purpose of Rulemaking: This rulemaking affects Human Capital Development. This rulemaking increases the Limited Utility Standard to $177, the Single Utility Standard to $37, and the Telephone Standard to $28. These changes are the result of the annual review of the Food Stamp Program standards required by Food and Nutrition Service regulations. The Food and Nutrition Service has approved these increased utility allowances.

16) Information and questions regarding this adopted amendment shall be directed to:

Tracie Drew, Bureau Chief
Bureau of Administrative Rules and Procedures
Department of Human Services
100 South Grand Avenue East
Harris Bldg., 3rd Floor
Springfield, Illinois 62762

217/785-9772

The full text of the Adopted Amendment begins on the next page:

DEPARTMENT OF HUMAN SERVICES

NOTICE OF ADOPTED AMENDMENT

TITLE 89: SOCIAL SERVICES
CHAPTER IV: DEPARTMENT OF HUMAN SERVICES
SUBCHAPTER b: ASSISTANCE PROGRAMS

PART 121
FOOD STAMPS

SUBPART A: APPLICATION PROCEDURES

Section
121.1 Application for Assistance
121.2 Time Limitations on the Disposition of an Application
121.3 Approval of an Application and Initial Authorization of Assistance
121.4 Denial of an Application
121.5 Client Cooperation
121.6 Emergency Assistance
121.7 Expedited Service
121.8 Express Stamps Application Project
121.10 Interviews

SUBPART B: NON-FINANCIAL FACTORS OF ELIGIBILITY

Section
121.18 Work Requirement
121.19 Ending a Voluntary Quit Disqualification (Repealed)
121.20 Citizenship
121.21 Residence
121.22 Social Security Numbers
121.23 Work Registration/Participation Requirements
121.24 Individuals Exempt from Work Registration Requirements
121.25 Failure to Comply with Work Provisions
121.26 Period of Sanction
121.27 Voluntary Job Quit/Reduction in Work Hours
121.28 Good Cause for Voluntary Job Quit/Reduction in Work Hours
121.29 Exemptions from Voluntary Quit/Reduction in Work Hours Rules

SUBPART C: FINANCIAL FACTORS OF ELIGIBILITY

Section

DEPARTMENT OF HUMAN SERVICES

NOTICE OF ADOPTED AMENDMENT

121.30 Unearned Income
121.31 Exempt Unearned Income
121.32 Education Benefits (Repealed)
121.33 Unearned Income In-Kind
121.34 Lump Sum Payments and Income Tax Refunds
121.40 Earned Income
121.41 Budgeting Earned Income
121.50 Exempt Earned Income
121.51 Income from Work/Study/Training Programs
121.52 Earned Income from Roomer and Boarder
121.53 Income From Rental Property
121.54 Earned Income In-Kind
121.55 Sponsors of Aliens
121.57 Assets
121.58 Exempt Assets
121.59 Asset Disregards

SUBPART D: ELIGIBILITY STANDARDS

Section
121.60 Net Monthly Income Eligibility Standards
121.61 Gross Monthly Income Eligibility Standards
121.62 Income Which Must Be Annualized
121.63 Deductions from Monthly Income
121.64 Food Stamp Benefit Amount

SUBPART E: HOUSEHOLD CONCEPT

Section
121.70 Composition of the Assistance Unit
121.71 Living Arrangement
121.72 Nonhousehold Members
121.73 Ineligible Household Members
121.74 Strikers
121.75 Students
121.76 Households Receiving AFDC, SSI, Interim Assistance and/or GA – Categorical Eligibility

SUBPART F: MISCELLANEOUS PROGRAM PROVISIONS

DEPARTMENT OF HUMAN SERVICES

NOTICE OF ADOPTED AMENDMENT

Section
121.80 Fraud Disqualification (Renumbered)
121.81 Initiation of Administrative Fraud Hearing (Repealed)
121.82 Definition of Fraud (Renumbered)
121.83 Notification To Applicant Households (Renumbered)
121.84 Disqualification Upon Finding of Fraud (Renumbered)
121.85 Court Imposed Disqualification (Renumbered)
121.90 Monthly Reporting and Retrospective Budgeting (Repealed)
121.91 Monthly Reporting (Repealed)
121.92 Budgeting
121.93 Issuance of Food Stamp Benefits
121.94 Replacement of the EBT Card or Food Stamp Benefits
121.95 Restoration of Lost Benefits
121.96 Uses For Food Coupons
121.97 Supplemental Payments
121.98 Client Training for the Electronic Benefits Transfer (EBT) System
121.105 State Food Program (Repealed)
121.107 New State Food Program
121.108 Transitional Food Stamp (TFS) Benefits
121.120 Redetermination of Eligibility
121.125 Redetermination of Earned Income Households
121.130 Residents of Shelters for Battered Women and their Children
121.131 Fleeing Felons and Probation/Parole Violators
121.135 Incorporation By Reference
121.140 Small Group Living Arrangement Facilities and Drug/Alcoholic Treatment Centers
121.145 Quarterly Reporting (Repealed)

SUBPART G: INTENTIONAL VIOLATIONS OF THE PROGRAM

Section
121.150 Definition of Intentional Violations of the Program
121.151 Penalties for Intentional Violations of the Program
121.152 Notification To Applicant Households
121.153 Disqualification Upon Finding of Intentional Violation of the Program
121.154 Court Imposed Disqualification

SUBPART H: FOOD STAMP EMPLOYMENT AND TRAINING PROGRAM

DEPARTMENT OF HUMAN SERVICES

NOTICE OF ADOPTED AMENDMENT

Section
121.160 Persons Required to Participate
121.162 Program Requirements
121.163 Vocational Training
121.164 Orientation (Repealed)
121.165 Community Work
121.166 Assessment and Employability Plan (Repealed)
121.167 Counseling/Prevention Services
121.170 Job Search Activity
121.172 Basic Education Activity
121.174 Job Readiness Activity
121.176 Work Experience Activity
121.177 Illinois Works Component (Repealed)
121.178 Job Training Component (Repealed)
121.179 JTPA Employability Services Component (Repealed)
121.180 Grant Diversion Component (Repealed)
121.182 Earnfare Activity
121.184 Sanctions for Non-cooperation with Food Stamp Employment and Training
121.186 Good Cause for Failure to Cooperate
121.188 Supportive Services
121.190 Conciliation
121.200 Types of Claims (Recodified)
121.201 Establishing a Claim for Intentional Violation of the Program (Recodified)
121.202 Establishing a Claim for Unintentional Household Errors and Administrative Errors (Recodified)
121.203 Collecting Claim Against Households (Recodified)
121.204 Failure to Respond to Initial Demand Letter (Recodified)
121.205 Methods of Repayment of Food Stamp Claims (Recodified)
121.206 Determination of Monthly Allotment Reductions (Recodified)
121.207 Failure to Make Payment in Accordance with Repayment Schedule (Recodified)
121.208 Suspension and Termination of Claims (Recodified)

SUBPART I: WORK REQUIREMENT FOR FOOD STAMPS

Section
121.220 Work Requirement Components (Repealed)
121.221 Meeting the Work Requirement with the Earnfare Component (Repealed)
121.222 Volunteer Community Work Component (Repealed)

DEPARTMENT OF HUMAN SERVICES

NOTICE OF ADOPTED AMENDMENT

121.223 Work Experience Component (Repealed)
121.224 Supportive Service Payments to Meet the Work Requirement (Repealed)
121.225 Meeting the Work Requirement with the Illinois Works Component (Repealed)
121.226 Meeting the Work Requirement with the JTPA Employability Services Component (Repealed)

AUTHORITY: Implementing Sections 12-4.4 through 12-4.6 and authorized by Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/12-4.4 through 12-4.6 and 12-13].

SOURCE: Adopted December 30, 1977; amended at 3 Ill. Reg. 5, p. 875, effective February 2, 1979; amended at 3 Ill. Reg. 31, p. 109, effective August 3, 1979; amended at 3 Ill. Reg. 33, p. 399, effective August 18, 1979; amended at 3 Ill. Reg. 41, p. 165, effective October 11, 1979; amended at 3 Ill. Reg. 42, p. 230, effective October 9, 1979; amended at 3 Ill. Reg. 44, p. 173, effective October 19, 1979; amended at 3 Ill. Reg. 46, p. 36, effective November 2, 1979; amended at 3 Ill. Reg. 47, p. 96, effective November 13, 1979; amended at 3 Ill. Reg. 48, p. 1, effective November 15, 1979; peremptory amendment at 4 Ill. Reg. 3, p. 49, effective January 9, 1980; peremptory amendment at 4 Ill. Reg. 9, p. 259, effective February 23, 1980; amended at 4 Ill. Reg. 10, p. 253, effective February 27, 1980; amended at 4 Ill. Reg. 12, p. 551, effective March 10, 1980; emergency amendment at 4 Ill. Reg. 29, p. 294, effective July 8, 1980, for a maximum of 150 days; amended at 4 Ill. Reg. 37, p. 797, effective September 2, 1980; amended at 4 Ill. Reg. 45, p. 134, effective October 17, 1980; amended at 5 Ill. Reg. 766, effective January 2, 1981; amended at 5 Ill. Reg. 1131, effective January 16, 1981; amended at 5 Ill. Reg. 4586, effective April 15, 1981; peremptory amendment at 5 Ill. Reg. 5722, effective June 1, 1981; amended at 5 Ill. Reg. 7071, effective June 23, 1981; peremptory amendment at 5 Ill. Reg. 10062, effective October 1, 1981; amended at 5 Ill. Reg. 10733, effective October 1, 1981; amended at 5 Ill. Reg. 12736, effective October 29, 1981; amended at 6 Ill. Reg. 1653, effective January 17, 1982; amended at 6 Ill. Reg. 2707, effective March 2, 1982; amended at 6 Ill. Reg. 8159, effective July 1, 1982; amended at 6 Ill. Reg. 10208, effective August 9, 1982; amended at 6 Ill. Reg. 11921, effective September 21, 1982; amended at 6 Ill. Reg. 12318, effective October 1, 1982; amended at 6 Ill. Reg. 13754, effective November 1, 1982; amended at 7 Ill. Reg. 394, effective January 1, 1983; codified at 7 Ill. Reg. 5195; amended at 7 Ill. Reg. 5715, effective May 1, 1983; amended at 7 Ill. Reg. 8118, effective June 24, 1983; peremptory amendment at 7 Ill. Reg. 12899, effective October 1, 1983; amended at 7 Ill. Reg. 13655, effective October 4, 1983; peremptory amendment at 7 Ill. Reg. 16067, effective November 18, 1983; amended at 7 Ill. Reg. 16169, effective November 22, 1983; amended at 8 Ill. Reg. 5673, effective April 18, 1984; amended at 8 Ill. Reg. 7249, effective May 16, 1984; peremptory amendment at 8 Ill. Reg. 10086, effective July 1, 1984; amended at 8 Ill. Reg. 13284, effective July 16, 1984; amended at 8 Ill. Reg. 17900, effective September 14, 1984; amended (by adding Section being codified with no substantive change) at 8 Ill. Reg. 17898; peremptory amendment at 8 Ill. Reg. 19690,

effective October 1, 1984; peremptory amendment at 8 Ill. Reg. 22145, effective November 1, 1984; amended at 9 Ill. Reg. 302, effective January 1, 1985; amended at 9 Ill. Reg. 6804, effective May 1, 1985; amended at 9 Ill. Reg. 8665, effective May 29, 1985; peremptory amendment at 9 Ill. Reg. 8898, effective July 1, 1985; amended at 9 Ill. Reg. 11334, effective July 8, 1985; amended at 9 Ill. Reg. 14334, effective September 6, 1985; peremptory amendment at 9 Ill. Reg. 15582, effective October 1, 1985; amended at 9 Ill. Reg. 16889, effective October 16, 1985; amended at 9 Ill. Reg. 19726, effective December 9, 1985; amended at 10 Ill. Reg. 229, effective December 20, 1985; peremptory amendment at 10 Ill. Reg. 7387, effective April 21, 1986; peremptory amendment at 10 Ill. Reg. 7941, effective May 1, 1986; amended at 10 Ill. Reg. 14692, effective August 29, 1986; peremptory amendment at 10 Ill. Reg. 15714, effective October 1, 1986; Sections 121.200 thru 121.208 recodified to 89 Ill. Adm. Code 165 at 10 Ill. Reg. 21094; peremptory amendment at 11 Ill. Reg. 3761, effective February 11, 1987; emergency amendment at 11 Ill. Reg. 3754, effective February 13, 1987, for a maximum of 150 days; emergency amendment at 11 Ill. Reg. 9968, effective May 15, 1987, for a maximum of 150 days; amended at 11 Ill. Reg. 10269, effective May 22, 1987; amended at 11 Ill. Reg. 10621, effective May 25, 1987; peremptory amendment at 11 Ill. Reg. 11391, effective July 1, 1987; peremptory amendment at 11 Ill. Reg. 11855, effective June 30, 1987; emergency amendment at 11 Ill. Reg. 12043, effective July 6, 1987, for a maximum of 150 days; amended at 11 Ill. Reg. 13635, effective August 1, 1987; amended at 11 Ill. Reg. 14022, effective August 10, 1987; emergency amendment at 11 Ill. Reg. 15261, effective September 1, 1987, for a maximum of 150 days; amended at 11 Ill. Reg. 15480, effective September 4, 1987; amended at 11 Ill. Reg. 15634, effective September 11, 1987; amended at 11 Ill. Reg. 18218, effective October 30, 1987; peremptory amendment at 11 Ill. Reg. 18374, effective October 30, 1987; amended at 12 Ill. Reg. 877, effective December 30, 1987; emergency amendment at 12 Ill. Reg. 1941, effective December 31, 1987, for a maximum of 150 days; amended at 12 Ill. Reg. 4204, effective February 5, 1988; amended at 12 Ill. Reg. 9678, effective May 23, 1988; amended at 12 Ill. Reg. 9922, effective June 1, 1988; amended at 12 Ill. Reg. 11463, effective June 30, 1988; amended at 12 Ill. Reg. 12824, effective July 22, 1988; emergency amendment at 12 Ill. Reg. 14045, effective August 19, 1988, for a maximum of 150 days; peremptory amendment at 12 Ill. Reg. 15704, effective October 1, 1988; peremptory amendment at 12 Ill. Reg. 16271, effective October 1, 1988; amended at 12 Ill. Reg. 20161, effective November 30, 1988; amended at 13 Ill. Reg. 3890, effective March 10, 1989; amended at 13 Ill. Reg. 13619, effective August 14, 1989; peremptory amendment at 13 Ill. Reg. 15859, effective October 1, 1989; amended at 14 Ill. Reg. 729, effective January 1, 1990; amended at 14 Ill. Reg. 6349, effective April 13, 1990; amended at 14 Ill. Reg. 13202, effective August 6, 1990; peremptory amendment at 14 Ill. Reg. 15158, effective October 1, 1990; amended at 14 Ill. Reg. 16983, effective September 30, 1990; amended at 15 Ill. Reg. 11150, effective July 22, 1991; amended at 15 Ill. Reg. 11957, effective August 12, 1991; peremptory amendment at 15 Ill. Reg. 14134, effective October 1, 1991; emergency amendment at 16 Ill. Reg. 757, effective January 1, 1992, for a maximum of 150

days; amended at 16 Ill. Reg. 10011, effective June 15, 1992; amended at 16 Ill. Reg. 13900, effective August 31, 1992; emergency amendment at 16 Ill. Reg. 16221, effective October 1, 1992, for a maximum of 150 days; peremptory amendment at 16 Ill. Reg. 16345, effective October 1, 1992; amended at 16 Ill. Reg. 16624, effective October 23, 1992; amended at 17 Ill. Reg. 644, effective December 31, 1992; amended at 17 Ill. Reg. 4333, effective March 19, 1993; amended at 17 Ill. Reg. 14625, effective August 26, 1993; emergency amendment at 17 Ill. Reg. 15149, effective September 7, 1993, for a maximum of 150 days; peremptory amendment at 17 Ill. Reg. 17477, effective October 1, 1993; expedited correction at 17 Ill. Reg. 21216, effective October 1, 1993; amended at 18 Ill. Reg. 2033, effective January 21, 1994; emergency amendment at 18 Ill. Reg. 2509, effective January 27, 1994, for a maximum of 150 days; amended at 18 Ill. Reg. 3427, effective February 28, 1994; amended at 18 Ill. Reg. 8921, effective June 3, 1994; amended at 18 Ill. Reg. 12829, effective August 5, 1994; amended at 18 Ill. Reg. 14103, effective August 26, 1994; amended at 19 Ill. Reg. 5626, effective March 31, 1995; amended at 19 Ill. Reg. 6648, effective May 5, 1995; emergency amendment at 19 Ill. Reg. 12705, effective September 1, 1995, for a maximum of 150 days; peremptory amendment at 19 Ill. Reg. 13595, effective October 1, 1995; amended at 20 Ill. Reg. 1593, effective January 11, 1996; peremptory amendment at 20 Ill. Reg. 2229, effective January 17, 1996; amended at 20 Ill. Reg. 7902, effective June 1, 1996; amended at 20 Ill. Reg. 11935, effective August 14, 1996; emergency amendment at 20 Ill. Reg. 13381, effective October 1, 1996, for a maximum of 150 days; emergency amendment at 20 Ill. Reg. 13668, effective October 8, 1996, for a maximum of 150 days; amended at 21 Ill. Reg. 3156, effective February 28, 1997; amended at 21 Ill. Reg. 7733, effective June 4, 1997; recodified from the Department of Public Aid to the Department of Human Services at 21 Ill. Reg. 9322; emergency amendment at 22 Ill. Reg. 1954, effective January 1, 1998, for a maximum of 150 days; amended at 22 Ill. Reg. 5502, effective March 4, 1998; amended at 22 Ill. Reg. 7969, effective May 15, 1998; emergency amendment at 22 Ill. Reg. 10660, effective June 1, 1998, for a maximum of 150 days; emergency amendment at 22 Ill. Reg. 12167, effective July 1, 1998, for a maximum of 150 days; amended at 22 Ill. Reg. 16230, effective September 1, 1998; amended at 22 Ill. Reg. 19787, effective October 28, 1998; emergency amendment at 22 Ill. Reg. 19934, effective November 1, 1998, for a maximum of 150 days; amended at 22 Ill. Reg. 20099, effective November 1, 1998; emergency amendment at 23 Ill. Reg. 2601, effective February 1, 1999, for a maximum of 150 days; amended at 23 Ill. Reg. 3374, effective March 1, 1999; amended at 23 Ill. Reg. 7285, effective June 18, 1999; emergency amendment at 23 Ill. Reg. 13253, effective October 13, 1999, for a maximum of 150 days; emergency amendment at 24 Ill. Reg. 3871, effective February 24, 2000, for a maximum of 150 days; amended at 24 Ill. Reg. 4180, effective March 2, 2000; amended at 24 Ill. Reg. 10198, effective June 27, 2000; amended at 24 Ill. Reg. 15428, effective October 10, 2000; emergency amendment at 24 Ill. Reg. 15468, effective October 1, 2000, for a maximum of 150 days; amended at 25 Ill. Reg. 845, effective January 5, 2001; amended at 25 Ill. Reg. 2423, effective January 25, 2001; emergency amendment at 25 Ill. Reg. 2439, effective January 29, 2001, for a

maximum of 150 days; emergency amendment at 25 Ill. Reg. 3707, effective March 1, 2001, for a maximum of 150 days; emergency expired July 28, 2001; amended at 25 Ill. Reg. 7720, effective June 7, 2001; amended at 25 Ill. Reg. 10823, effective August 12, 2001; amended at 25 Ill. Reg. 11856, effective August 31, 2001; emergency amendment at 25 Ill. Reg. 13309, effective October 1, 2001, for a maximum of 150 days; amended at 26 Ill. Reg. 151, effective January 1, 2002; amended at 26 Ill. Reg. 2025, effective February 1, 2002; amended at 26 Ill. Reg. 13530, effective September 3, 2002; peremptory amendment at 26 Ill. Reg. 15099, effective October 1, 2002; amended at 26 Ill. Reg. 16484, effective October 25, 2002; amended at 27 Ill. Reg. 2889, effective February 7, 2003; expedited correction at 27 Ill. Reg. 14262, effective February 7, 2003; amended at 27 Ill. Reg. 4583, effective February 28, 2003; amended at 27 Ill. Reg. 7273, effective April 7, 2003; amended at 27 Ill. Reg. 12569, effective July 21, 2003; peremptory amendment at 27 Ill. Reg. 15604, effective October 1, 2003; amended at 27 Ill. Reg. 16108, effective October 6, 2003; amended at 27 Ill. Reg. 18445, effective November 20, 2003; amended at 28 Ill. Reg. 1104, effective December 31, 2003; amended at 28 Ill. Reg. 3857, effective February 13, 2004; amended at 28 Ill. Reg. 10393, effective July 6, 2004; peremptory amendment at 28 Ill. Reg. 13834, effective October 1, 2004; emergency amendment at 28 Ill. Reg. 15323, effective November 10, 2004, for a maximum of 150 days; emergency expired April 8, 2005; amended at 29 Ill. Reg. 2701, effective February 4, 2005; amended at 29 Ill. Reg. 5499, effective April 1, 2005; peremptory amendment at 29 Ill. Reg. 12132, effective July 14, 2005; emergency amendment at 29 Ill. Reg. 16042, effective October 4, 2005, for a maximum of 150 days; emergency expired March 2, 2006; peremptory amendment at 29 Ill. Reg. 16538, effective October 4, 2005; emergency amendment at 30 Ill. Reg. 7804, effective April 6, 2006, for a maximum of 150 days; emergency expired September 2, 2006; amended at 30 Ill. Reg. 11236, effective June 12, 2006; amended at 30 Ill. Reg. 13863, effective August 1, 2006; amended at 30 Ill. Reg. 15681, effective September 12, 2006; peremptory amendment at 30 Ill. Reg. 16470, effective October 1, 2006; amended at 31 Ill. Reg. 6991, effective April 30, 2007; amended at 31 Ill. Reg. 10482, effective July 9, 2007; amended at 31 Ill. Reg. 11318, effective July 23, 2007.

SUBPART D: ELIGIBILITY STANDARDS

Section 121.63 Deductions from Monthly Income

a) The deductions described in this Section shall be allowed in the determination of the adjusted net monthly food stamp income.

b) Earned Income Deduction. Eighty percent of total gross earned income is considered. See Sections 121.40 through 121.54 for a description of earned income.

c) Standard Deduction. The standard deduction for a household size of one through three persons is $134. The standard deduction for a household size of four persons is $139. The standard deduction for a household size of five persons is $162. For households of six or more persons, the standard deduction is $186.

d) Dependent Care Deduction

1) The dependent care deduction consists of payments for the care of a child or other dependent when necessary for a household member to accept or continue employment or to seek employment in compliance with the job search criteria or to attend training or pursue education which is preparatory for employment (see 89 Ill. Adm. Code 112.70 through 112.84).

2) The amount of the deduction is to be determined by the actual costs for care and is not to exceed $200 per month for each child under age 2 and $175 per month for each other dependent household member.

e) Child Support Deduction. The child support deduction is the amount of legally obligated child support paid by a household member to or for a nonhousehold member.

f) Shelter Costs Deduction

1) The shelter deduction is the amount of shelter costs that exceeds 50% of the household's total income after the allowable deductions in subsections (b), (c), (d), and (e) of this Section have been made. The shelter deduction shall not exceed $417.

2) If the household contains a member who is elderly or disabled, as defined at 7 CFR 271.2 (2005) and Section 121.61, there is no limit on the amount of the excess shelter deduction.

3) Shelter costs include only the following:

A) continuing charges for the shelter occupied by the household (rent, mortgage and other charges leading to the ownership of the shelter, including interest on such charges);

B) property taxes, State and local assessments and insurance on the structure itself; and

C) utility costs, as described in subsection (g) of this Section.

4) Shelter costs for a home temporarily unoccupied by the household because of employment or training away from home, illness or abandonment caused by a natural disaster or casualty loss, if:

A) the household intends to return to the home;

B) the current occupants of the home, if any, are not claiming the shelter costs for food stamp purposes; and

C) the home is not leased or rented during the absence of the household.

5) Charges for repair of a home which was damaged or destroyed due to a natural disaster. Shelter costs shall not include repair charges which have been or will be reimbursed by private or public relief agencies, insurance companies or any other source.

g) Utility Costs

1) Utility costs include:

A) the cost of heating and cooking fuel, air conditioning, electricity, water, sewerage, garbage and trash collection;

B) basic service fee for one telephone (including tax on the basic fee) of $28~~27~~; and

C) fees charged by the utility provider for initial installation.

2) Utility deposits are not considered to be utility costs.

3) A standard must be used if the household is billed for utilities. See Section 121.63(g)(7) for households that claim utility expenses for an unoccupied home. Households that are billed for heating or air

conditioning, or both, or heating, air conditioning and electricity, must use the air conditioning/heating standard allowance of $299. Those households that are not billed for air conditioning or heating but are billed for at least two other utilities must use the limited utility standard allowance of $177~~165~~. Those households that are not billed for air conditioning or heating but are billed for a single utility, other than telephone, must use the single utility standard allowance of $37~~32~~. If only a separately-billed telephone expense is claimed, the basic telephone allowance of $28~~27~~ per month will be allowed. Households living in rental housing who are billed on a regular basis by a landlord for costs for utilities must use the appropriate standard.

4) A household that is billed less often than monthly for its costs for utilities must continue to use the appropriate standard between billing months.

5) Households in public housing or privately-owned rental units that receive a bill for over-usage are entitled to use the air conditioning/heating standard allowance. When households (as defined at 7 CFR 273.1(a) (2005)) live together, the air conditioning/heating standard allowance, the limited utility standard allowance, or the single utility standard allowance, whichever is appropriate, shall be allowed for each household that contributes toward the utility costs whether or not each household participates in the program.

6) Households whose expense for heat or electricity, or both, is covered by indirect energy assistance payments under the Low Income Home Energy Program (89 Ill. Adm. Code 109) shall be entitled to the air conditioning/heating standard allowance (7 CFR 273.9 and 273.10(d)(6) (2005)). Households who receive, apply for, or anticipate applying for a Low Income Energy Assistance Program (IHEAP) (89 Ill. Adm. Code 109) payment during the 12-month period, beginning with the date of the food stamp application, shall be allowed the air conditioning/heating standard (7 CFR 273.9). The provisions of subsection (f)(3) of this Section are applicable to households whose expenses for heating or electricity, or both, are covered by indirect energy assistance payments.

7) A household that has both an occupied home and an unoccupied home is entitled to only one standard. The appropriate utility standard may be used for the home the household chooses.

DEPARTMENT OF HUMAN SERVICES

NOTICE OF ADOPTED AMENDMENT

h) Excess Medical Deduction. A deduction for excess medical expenses shall be allowed for households which contain an elderly or disabled member as defined at 7 CFR 271.2 (2005) and Section 121.61. The medical expenses incurred by the qualifying household member which are over $35 will be deducted, if the expenses will not be reimbursed by insurance or a third party.

(Source: Amended at 31 Ill. Reg. 11318, effective July 23, 2007)

DEPARTMENT OF HUMAN SERVICES

NOTICE OF ADOPTED AMENDMENT

1) Heading of the Part: Determination of Need (DON) and Resulting Service Cost Maximums (SCMs)

2) Code Citation: 89 Ill. Adm. Code 679

3) Section Number: 679.30 — Adopted Action: Amendment

4) Statutory Authority: Implementing Section 3 of the Disabled Persons Rehabilitation Act [20 ILCS 2405/3]

5) Effective Date of Amendment: July 18, 2007

6) Does this rulemaking contain an automatic repeal date? No

7) Does this adopted amendment contain incorporations by reference? No

8) A copy of the adopted amendment, including any material incorporated by reference, is on file in the agency's principal office and is available for public inspection.

9) Notice of Proposal Published in the Illinois Register: 31 Ill. Reg. 2737; February 16, 2007

10) Has JCAR issued a Statement of Objection to this amendment? No

11) Differences between proposal and final version: No changes were made

12) Have all the changes agreed upon by the agency and JCAR been made as indicated in the agreements issued by JCAR? No changes were made

13) Will this adopted amendment replace any emergency rulemaking currently in effect? No

14) Are there any amendments pending on this Part? No

15) Summary and Purpose of Amendment: This rulemaking corrects an error in 679.30(c)(2). It should be Part B instead of Part A.

16) Information and questions regarding this adopted amendment shall be directed to:

DEPARTMENT OF HUMAN SERVICES

NOTICE OF ADOPTED AMENDMENT

Tracie Drew, Chief
Bureau of Administrative Rules and Procedures
Department of Human Services
100 South Grand Avenue East
Harris Building, 3rd Floor
Springfield, Illinois 62762

217/785-9772

17) Does this adopted amendment require the preview of the Procurement Policy Board as specified in Section 5-25 of the Illinois Procurement Code? No

The full text of the Adopted Amendment begins on the next page:

DEPARTMENT OF HUMAN SERVICES

NOTICE OF ADOPTED AMENDMENT

TITLE 89: SOCIAL SERVICES
CHAPTER IV: DEPARTMENT OF HUMAN SERVICES
SUBCHAPTER d: HOME SERVICES PROGRAM

PART 679
DETERMINATION OF NEED (DON) AND
RESULTING SERVICE COST MAXIMUMS (SCMs)

Section

679.10 General Provisions
679.20 Composition of the DON
679.30 Scoring of the DON Except for Respite Cases
679.40 Scoring the DON for Respite Cases
679.50 Service Cost Maximums (SCMs)

AUTHORITY: Implementing Section 3 of the Disabled Persons Rehabilitation Act [20 ILCS 2405/3].

SOURCE: Adopted at 19 Ill. Reg. 5062, effective March 21, 1995; amended at 20 Ill. Reg. 6303, effective April 18, 1996; amended at 21 Ill. Reg. 2674, effective February 7, 1997; recodified from the Department of Rehabilitation Services to the Department of Human Services at 21 Ill. Reg. 9325; emergency amendment at 22 Ill. Reg. 2328, effective January 12, 1998, for a maximum of 150 days; amended at 22 Ill. Reg. 10445, effective May 29, 1998; emergency amendment at 22 Ill. Reg. 16031, effective August 14, 1998, for a maximum of 150 days; emergency expired on January 11, 1999; amended at 23 Ill. Reg. 1615, effective January 20, 1999; amended at 23 Ill. Reg. 7492, effective June 17, 1999; emergency amendment at 23 Ill. Reg. 10526, effective August 10, 1999, for a maximum of 150 days; amended at 24 Ill. Reg. 285, effective December 23, 1999; amended at 24 Ill. Reg. 6563, effective May 1, 2000; emergency amendment at 24 Ill. Reg. 9966, effective July 1, 2000, for a maximum of 150 days; amended at 24 Ill. Reg. 17126, effective November 3, 2000; emergency amendment at 27 Ill. Reg. 17428, effective November 6, 2003, for a maximum of 150 days; emergency expired April 3, 2004; amended at 28 Ill. Reg. 7056, effective April 30, 2004; emergency amendment at 28 Ill. Reg. 15178, effective November 8, 2004, for a maximum of 150 days; emergency expired April 6, 2005; amended at 31 Ill. Reg. 422, effective December 29, 2006; amended at 31 Ill. Reg. 11332, effective July 18, 2007.

Section 679.30 Scoring of the DON Except for Respite Cases

a) An individual receiving a 14 or more on the Mini-Mental Status Examination

shall receive "zero" points towards his/her column A score. An individual receiving less than 14 points shall receive an additional "10" points added to his/her column A score for the determination of eligibility and a SCM.

b) The remaining two sections of the DON measure the individual's ability to complete the ADLs. The ADLs are specifically: eating, bathing, grooming, dressing, transferring, incontinence care, preparing meals, being alone, telephoning, managing money, routine health care tasks (or those health care tasks not requiring specialized training), specialized health care tasks (or those requiring assistance from trained medical practitioners), necessary travel outside the home, laundry, and housework.

1) Part A of the DON measures the individual's need for assistance in the completion of each of the ADLs on the following rating scale.

A) "0" – the individual can perform all essential components of the ADL with or without an existing assistive device;

B) "1" – the individual can perform most of the ADL, with or without an existing assistive device, but requires some supervision and/or assistance to ensure the task is fully completed;

C) "2" – the individual requires a great deal of supervision and/or assistance, with or without existing assistive devices, in the completion of the essential components of the task; and

D) "3" – the individual cannot perform any of the essential components of the task, with or without existing assistive devices and requires constant supervision and/or assistance.

2) Part B of the DON measures the individual's unmet need for care in the completion of the ADLs on the following scale.

A) "0" – the individual has no unmet need for care in that the individual needs no assistance in completion of the essential components of the task, or family and/or other resources already provide for this task;

B) "1" – the individual's need for assistance in the completion of the

task is met at least 50% of the time, and, without periodic assistance, there is a risk to the individual's health and safety;

C) "2" – the individual's need for assistance in the completion of the task is met less than 50% of the time and, without assistance, there is moderate risk to the individual's health and safety; and

D) "3" – the individual's need for assistance in the completion of the task is seldom (less than 10% of the time) or never met and, without assistance, there is extreme risk to the individual's health and safety.

c) In administering the DON for children, the assessor should ensure the ratings given reflect limitations due to the individual's disability and not the individual's age and/or the additional burden placed on the caregiver.

1) On Part A, determine if a child of the individual's age should be able to complete all or part of the task. If the inability to perform the task relates only to the individual's age, a score of "zero" should be given. Otherwise, score "1", "2", or "3" according to the individual's impairment level.

2) On Part B~~A~~, determine the additional burden placed on a caregiver providing the service. If, because of the individual's age, there is no increased burden, a score of "0" should be given. If there is an increased burden on the caregiver due to the individual's disability, score "1", "2", or "3" according to the increased level of burden in providing the task.

(Source: Amended at 31 Ill. Reg. 11332, effective July 18, 2007)

SECRETARY OF STATE

NOTICE OF ADOPTED AMENDMENTS

1) Heading of the Part: Sale of Information

2) Code Citation: 92 Ill. Adm. Code 1002

3)

Section Numbers:	Adopted Action:
1002.40	Amendment
1002.60	Amendment
1002.70	Amendment

4) Statutory Authority: Implementing Section 2-123, and authorized by Sections 2-104, 2-107, and 2-123, of the Illinois Vehicle Title and Registration Law [625 ILCS 5/2-123, 2-104 and 2-107], and 18 U.S.C. 2721

5) Effective Date of Amendments: July 23, 2007

6) Does this rulemaking contain an automatic repeal date? No

7) Does this rulemaking contain incorporations by reference? No

8) A copy of the adopted amendments, including any material incorporated by reference, is on file in the agency's principal office and is available for public inspection.

9) Notice of Proposed Amendments Published in the Illinois Register: 30 Ill. Reg. 17722; November 13, 2006

10) Has JCAR issued a Statement of Objection to the amendments? No

11) Differences between proposal and final version: No substantive changes made between proposal and adoption. All technical changes recommended by JCAR were made.

12) Have all the changes agreed upon by the agency and JCAR been made as indicated in the agreements issued by JCAR? Yes

13) Will this rulemkaing replace any emergency rulemaking currently in effect? No

14) Are there any amendments pending on this Part? No

SECRETARY OF STATE

NOTICE OF ADOPTED AMENDMENTS

15) Summary and Purpose of Amendments: In response to recent data breaches in both the public and private sector, the Secretary of State's Office is strengthening efforts to protect its data.

16) Information and questions regarding these adopted amendments shall be directed to:

Secretary of State
Brenda Glahn, Assistant General Counsel
298 Howlett Building
Springfield, IL 62701

217/785-3094

17) Do the amendments require the preview of the Procurement Policy Board as specified in Section 5-25 of the Illinois Procurement Code? No

The full text of the Adopted Amendments begin on the next page:

SECRETARY OF STATE

NOTICE OF ADOPTED AMENDMENTS

TITLE 92: TRANSPORTATION
CHAPTER II: SECRETARY OF STATE

PART 1002
SALE OF INFORMATION

Section

1002.10 Applicability
1002.20 Definitions
1002.30 Fees
1002.40 Requests
1002.42 Impermissible Uses of Personal Information
1002.45 Request for an Individual's Driving, Registration, or Title Information
1002.50 Lists of Purchasers
1002.60 Contract
1002.70 Public Records
1002.80 Lists of Licenses
1002.90 Social Security Numbers

AUTHORITY: Implementing Section 2-123, and authorized by Sections 2-104, 2-107, and 2-123, of the Illinois Vehicle Title and Registration Law [625 ILCS 5/2-123, 2-104 and 2-107] and 18 USC 2721.

SOURCE: Emergency rules adopted at 7 Ill. Reg. 11760, effective September 14, 1983; adopted and codified at 8 Ill. Reg. 2522, effective February 11, 1984; amended at 16 Ill. Reg. 13088, effective August 11, 1992; amended at 18 Ill. Reg. 18118, effective December 9, 1994; amended at 21 Ill. Reg. 466, effective January 1, 1997; amended at 31 Ill. Reg. 11337, effective July 23, 2008.

Section 1002.40 Requests

a) All requests for any type of information for sale pursuant to Section 2-123 must be in writing, be signed before a notary by the person requesting the information, and include~~includes~~ that person's address, the purpose of the request, the specific information or type of information sought, the name and address of any organization represented, the position of the requestor in the organization, and the identification of the requestor.

b) Information obtained by means of a computer connection between the Secretary's

computers and those of any organization shall~~need not~~ be requested in writing, including a certified statement of use, and a record shall be kept as required in subsection~~subsections~~ (a)~~ or (b) above~~. The requesting organization shall comply with the provisions of subsection (a) ~~above~~ at the time of the original request and contract period.

(Source: Amended at 31 Ill. Reg. 11337, effective July 23, 2007)

Section 1002.60 Contract

All commercial or business purchasers of the drivers, vehicle, or title lists shall sign a contract with the Secretary. The contract~~, which~~ shall include disclosure of the commercial use, which shall not include commercial solicitation purposes, or disclosure of the permissible use of personal information, if applicable. The contract~~, and~~ shall contain those terms the Secretary~~he/she~~ deems necessary and appropriate to protect the integrity of the lists, including, but not limited to, a requirement that the list ~~will~~ not be used for criminal or immoral purposes, that violation of any terms of the contract could result in the Secretary's denial of sale of the lists to the purchaser for a term of 5 years~~,~~ and the return of the vehicles, titles or drivers list to the Secretary. The redisclosure of information is prohibited, except to the extent necessary to effectuate the purpose for which the original disclosure of the information was permitted. Any authorized recipient that resells or redisclosures personal information covered by this Part must keep, for a period of 5 years, records identifying each person or entity that receives information~~,~~ and the permitted purpose for which the information will be used. The purchaser~~, and~~ must make these~~such~~ records available to the Secretary of State upon request.

(Source: Amended at 31 Ill. Reg. 11337, effective July 23, 2007)

Section 1002.70 Public Records

a) Subject to the federal Driver's Privacy Protection Act (18 USC 2721 et seq.) and 625 ILCS 5/2-123, the ~~The~~ drivers lists, title lists and~~,~~ vehicle lists, and lists of purchasers ~~for~~ of these lists, are public records and may be examined~~,~~ and purchased for the appropriate fees ~~by anyone~~ for a legitimate and lawful purpose and use.

b) The Secretary may sell the lists in their entirety on the medium the Secretary~~he~~ deems most economical and efficient, or in any reasonable part, such as by county or counties, age group, zip code groups, make or model of car, restriction codes, license issue data, license expiration data, city, or other governmental or

geographic division. No listing shall be prepared and sold by the Secretary to any person or organization for commercial solicitation purposes. Lists shall not be available as compiled by any form of driver's license sanction; i.e., suspension, revocation, cancellation, or denial. No list will be prepared and sold by the Secretary for any person or organization for commercial purposes if~~where~~ the request is for the Secretary to extract from a larger group certain persons or types of persons to be solicited by the requestor, when the requestor, by the purchase of the larger group of names, titles, or registrations, could extract the information sought.

~~c) The DUI listing shall only be made available if the person requesting the list states the specific purpose for the request and the purpose is not for personal or commercial benefit nor solicitation purposes.~~

(Source: Amended at 31 Ill. Reg. 11337, effective July 23, 2007)

SECRETARY OF STATE

NOTICE OF ADOPTED AMENDMENT

1) Heading of the Part: Issuance of Licenses

2) Code Citation: 92 Ill. Adm. Code 1030

3) Section Number: 1030.84 — Adopted Action: Amendment

4) Statutory Authority: 625 ILCS 5/2-104 and 625 ILCS 5/6-521

5) Effective Date of Amendment: July 18, 2007

6) Does this rulemaking contain an automatic repeal date? No

7) Does this amendment contain incorporations by reference? Yes

8) A copy of the adopted amendment, including any material incorporated by reference, is on file in the agency's principal office and is available for public inspection.

9) Notice of Proposal Published in Illinois Register: 31 Ill. Reg. 6030; April 20, 2007

10) Has JCAR issued a Statement of Objection to this rulemaking? No

11) Differences between proposal and final version: Technical, non-substantive changes were made as suggested by JCAR.

12) Have all the changes agreed upon by the agency and JCAR been made as indicated in the agreements issued by JCAR? Yes

13) Will this amendment replace any emergency rulemaking currently in effect? No

14) Are there any amendments pending on this Part? Yes

Section Number:	Proposed Action:	Illinois Register Citation:
1030.APPENDIX B	Amendment	31 Ill. Reg. 9828; July 2, 2007

15) Summary and Purpose of Amendment: This amendment is necessary to update the definitions for vehicle inspection to come into compliance with the Federal Motor Carrier Safety Regulations.

SECRETARY OF STATE

NOTICE OF ADOPTED AMENDMENT

16) Information and questions regarding this adopted amendment shall be directed to:

Arlene J. Pulley
Office of the Secretary of State
Driver Services Department
2701 South Dirksen Parkway
Springfield, Illinois 62723

217/557-4462

The full text of the Adopted Amendment begins on the next page:

SECRETARY OF STATE

NOTICE OF ADOPTED AMENDMENT

TITLE 92: TRANSPORTATION
CHAPTER II: SECRETARY OF STATE

PART 1030
ISSUANCE OF LICENSES

Section
1030.10 What Persons Shall Not be Licensed or Granted Permits
1030.11 Procedure for Obtaining a Driver's License/Temporary Visitor's Driver's License
1030.13 Denial of License or Permit
1030.15 Cite for Re-examination
1030.16 Physical and Mental Evaluation
1030.17 Errors in Issuance of Driver's License/Cancellation
1030.18 Medical Criteria Affecting Driver Performance
1030.20 Classification of Drivers – References
1030.30 Classification Standards
1030.40 Fifth Wheel Equipped Trucks
1030.50 Bus Driver's Authority, Religious Organization and Senior Citizen Transportation
1030.55 Commuter Van Driver Operating a For-Profit Ridesharing Arrangement
1030.60 Third-Party Certification Program
1030.63 Religious Exemption for Social Security Numbers
1030.65 Instruction Permits
1030.70 Driver's License Testing/Vision Screening
1030.75 Driver's License Testing/Vision Screening With Vision Aid Arrangements Other Than Standard Eye Glasses or Contact Lenses
1030.80 Driver's License Testing/Written Test
1030.81 Endorsements
1030.82 Charter Bus Driver Endorsement Requirements
1030.83 Hazardous Material Endorsement
1030.84 Vehicle Inspection
1030.85 Driver's License Testing/Road Test
1030.86 Multiple Attempts – Written and/or Road Tests
1030.88 Exemption of Facility Administered Road Test
1030.89 Temporary Licenses
1030.90 Requirement for Photograph and Signature of Licensee on Driver's License
1030.91 Disabled Person/Handicapped Identification Card
1030.92 Restrictions
1030.93 Restricted Local Licenses
1030.94 Duplicate or Corrected Driver's License or Instruction Permit

SECRETARY OF STATE

NOTICE OF ADOPTED AMENDMENT

1030.95 Consular Licenses (Repealed)
1030.96 Seasonal Restricted Commercial Driver's License
1030.97 Invalidation of a Driver's License, Permit and/or Driving Privilege
1030.98 School Bus Commercial Driver's License
1030.100 Anatomical Gift Donor
1030.110 Emergency Medical Information Card
1030.115 Change-of-Address
1030.120 Issuance of a Probationary License
1030.130 Grounds for Cancellation of a Probationary License
1030.140 Use of Captured Images
1030.APPENDIX A Questions Asked of a Driver's License Applicant
1030.APPENDIX B Acceptable Identification Documents

AUTHORITY: Implementing Article I of the Illinois Driver Licensing Law of the Illinois Vehicle Code [625 ILCS 5/Ch. 6, Art. I] and authorized by Section 2-104(b) of the Illinois Vehicle Title and Registration Law of the Illinois Vehicle Code [625 ILCS 5/2-104(b)].

SOURCE: Filed March 30, 1971; amended at 3 Ill. Reg. 7, p. 13, effective April 2, 1979; amended at 4 Ill. Reg. 27, p. 422, effective June 23, 1980; amended at 6 Ill. Reg. 2400, effective February 10, 1982; codified at 6 Ill. Reg. 12674; amended at 9 Ill. Reg. 2716, effective February 20, 1985; amended at 10 Ill. Reg. 303, effective December 24, 1985; amended at 10 Ill. Reg. 18182, effective October 14, 1986; amended at 11 Ill. Reg. 9331, effective April 28, 1987; amended at 11 Ill. Reg. 18292, effective October 23, 1987; amended at 12 Ill. Reg. 3027, effective January 14, 1988; amended at 12 Ill. Reg. 13221, effective August 1, 1988; amended at 12 Ill. Reg. 16915, effective October 1, 1988; amended at 12 Ill. Reg. 19777, effective November 15, 1988; amended at 13 Ill. Reg. 5192, effective April 1, 1989; amended at 13 Ill. Reg. 7808, effective June 1, 1989; amended at 13 Ill. Reg. 12880, effective July 19, 1989; amended at 13 Ill. Reg. 12978, effective July 19, 1989; amended at 13 Ill. Reg. 13898, effective August 22, 1989; amended at 13 Ill. Reg. 15112, effective September 8, 1989; amended at 13 Ill. Reg. 17095, effective October 18, 1989; amended at 14 Ill. Reg. 4570, effective March 8, 1990; amended at 14 Ill. Reg. 4908, effective March 9, 1990; amended at 14 Ill. Reg. 5183, effective March 21, 1990; amended at 14 Ill. Reg. 8707, effective May 16, 1990; amended at 14 Ill. Reg. 9246, effective May 16, 1990; amended at 14 Ill. Reg. 9498, effective May 17, 1990; amended at 14 Ill. Reg. 10111, effective June 11, 1990; amended at 14 Ill. Reg. 10510, effective June 18, 1990; amended at 14 Ill. Reg. 12077, effective July 5, 1990; amended at 14 Ill. Reg. 15487, effective September 10, 1990; amended at 15 Ill. Reg. 15783, effective October 18, 1991; amended at 16 Ill. Reg. 2182, effective January 24, 1992; emergency amendment at 16 Ill. Reg. 12228, effective July 16, 1992, for a maximum of 150 days; emergency expired on December 13, 1992; amended at 16 Ill. Reg. 18087, effective November 17, 1992; emergency amendment

at 17 Ill. Reg. 1219, effective January 13, 1993, for a maximum of 150 days; amended at 17 Ill. Reg. 2025, effective February 1, 1993; amended at 17 Ill. Reg. 7065, effective May 3, 1993; amended at 17 Ill. Reg. 8275, effective May 24, 1993; amended at 17 Ill. Reg. 8522, effective May 27, 1993; amended at 17 Ill. Reg. 19315, effective October 22, 1993; amended at 18 Ill. Reg. 1591, effective January 14, 1994; amended at 18 Ill. Reg. 7478, effective May 2, 1994; amended at 18 Ill. Reg. 16457, effective October 24, 1994; amended at 19 Ill. Reg. 10159, effective June 29, 1995; amended at 20 Ill. Reg. 3891, effective February 14, 1996; emergency amendment at 20 Ill. Reg. 8358, effective June 4, 1996, for a maximum of 150 days; emergency amendment repealed in response to an objection of the Joint Committee on Administrative Rules at 20 Ill. Reg. 14279; amended at 21 Ill. Reg. 6588, effective May 19, 1997; amended at 21 Ill. Reg. 10992, effective July 29, 1997; amended at 22 Ill. Reg. 1466, effective January 1, 1998; emergency amendment at 23 Ill. Reg. 9552, effective August 1, 1999, for a maximum of 150 days; amended at 23 Ill. Reg. 13947, effective November 8, 1999; amended at 24 Ill. Reg. 1259, effective January 7, 2000; emergency amendment at 24 Ill. Reg. 1686, effective January 13, 2000, for a maximum of 150 days; amended at 24 Ill. Reg. 6955, effective April 24, 2000; emergency amendment at 24 Ill. Reg. 13044, effective August 10, 2000, for a maximum of 150 days; amended at 24 Ill. Reg. 18400, effective December 4, 2000; amended at 25 Ill. Reg. 959, effective January 5, 2001; amended at 25 Ill. Reg. 7742, effective June 5, 2001; amended at 25 Ill. Reg. 12646, effective September 24, 2001; emergency amendment at 25 Ill. Reg. 12658, effective September 24, 2001, for a maximum of 150 days; emergency expired February 20, 2002; amended at 26 Ill. Reg. 9961, effective June 24, 2002; amended at 27 Ill. Reg. 855, effective January 3, 2003; emergency amendment at 27 Ill. Reg. 7340, effective April 14, 2003, for a maximum of 150 days; emergency expired September 10, 2003; emergency amendment at 27 Ill. Reg. 16968, effective October 17, 2003, for a maximum of 150 days; emergency expired March 14, 2004; emergency amendment at 28 Ill. Reg. 384, effective January 1, 2004, for a maximum of 150 days; emergency expired May 29, 2004; amended at 28 Ill. Reg. 8895, effective June 14, 2004; amended at 28 Ill. Reg. 10776, effective July 13, 2004; amended at 29 Ill. Reg. 920, effective January 1, 2005; emergency amendment at 29 Ill. Reg. 2469, effective January 31, 2005, for a maximum of 150 days; emergency expired June 29, 2005; amended at 29 Ill. Reg. 9488, effective June 17, 2005; amended at 29 Ill. Reg. 12519, effective July 28, 2005; amended at 29 Ill. Reg. 13237, effective August 11, 2005; amended at 29 Ill. Reg. 13580, effective August 16, 2005; amended at 30 Ill. Reg. 910, effective January 6, 2006; amended at 30 Ill. Reg. 5621, effective March 7, 2006; amended at 30 Ill. Reg. 11365, effective June 15, 2006; emergency amendment at 30 Ill. Reg. 11409, effective June 19, 2006, for a maximum of 150 days; emergency expired November 15, 2006; amended at 31 Ill. Reg. 4782, effective March 12, 2007; amended at 31 Ill. Reg. 5096, effective March 15, 2007; amended at 31 Ill. Reg. 5864, effective March 29, 2007; amended at 31 Ill. Reg. 6370, effective April 12, 2007; amended at 31 Ill. Reg. 7643, effective May 16, 2007; amended at 31 Ill. Reg. 11342, effective July 18, 2007.

SECRETARY OF STATE

NOTICE OF ADOPTED AMENDMENT

Section 1030.84 Vehicle Inspection

a) For the purposes of this Section, terms shall be defined as follows:

"Examiner" – employee of the Secretary of State who is qualified to administer a road test.

"First Division Vehicle" – those motor vehicles that are designed to carry not more than ten persons.

"Commercial Motor Vehicle" or "CMV" – a motor vehicle, used in commerce, except those referred to in Section 6-500(6)(B) of the Illinois Vehicle Code, designed to transport passengers of property if:

the vehicle has a GVWR of 26,001 pounds or more or such a lesser GVWR as subsequently determined by federal regulations (49 CFR 383); or

any combination of vehicles with a GCWR of 26,001 pounds or more provided the GVWR of any vehicle or vehicles being towed is 10,001 pounds or more; or

the vehicle is designed to transport 16 persons; or

the vehicle is transporting hazardous materials and is required to be placarded in accordance with 49 CFR 172, subpart F. ~~having a GVWR of 26,001 pounds or more, or such lesser GVWR as subsequently determined by Federal regulations (49 CFR 383); or any combination of vehicles with a GCWR of 26,001 pounds or more, provided the GVWR of any vehicle(s) being towed is 10,001 pounds or more; or a vehicle designed to transport 16 or more persons; or a vehicle transporting hazardous materials that is required to be placarded. The definition does not include recreational vehicles as defined in Section 1-169 of the Illinois Vehicle Code [625 ILCS 5/1-169] when operated primarily for personal use, military vehicles being operated by non-civilian personnel or firefighting equipment owned or operated by or for a governmental entity.~~

"Gross Combination Weight Rating" or "~~(~~GCWR~~)~~" – the GVWR of the power unit plus the GVWR of the towed unit or units. In the absence of a value

specified by the manufacturer, GCWR is determined by adding the GVWR of the power unit and the total weight of the towed unit and any load on the unit.~~unit(s) or the combined registered weight of the power unit plus the towed unit, whichever is greater.~~

"Gross Vehicle Weight Rating" or "~~(~~GVWR~~)~~" – the value specified by the manufacturer or manufacturers~~manufacturer(s)~~ as the maximum loaded weight of a single vehicle.~~, or the registered gross weight, whichever is greater.~~

"Hazardous Materials" – substance or material in a quantity and form which may pose an unreasonable risk to health and safety or property when transported in commerce (49 USCA 1802).

"Mandatory Insurance" – requirement of insurance as provided by Article 6 of the Illinois Safety and Family Financial Responsibility Law of the Illinois Vehicle Code [625 ILCS 5/Ch. 7, Art. VI].

"Mandatory Liability Insurance Policy" – a liability insurance policy issued in amounts no less than the minimum amounts set for bodily injury or death and for destruction of property pursuant to Section 7-203 of the Illinois Vehicle Code [625 ILCS 5/7-203], and issued in accordance with the requirements of Sections 143a and 143a-2 of the Illinois Insurance Code [215 ILCS 5/143a and 143a-2]. The definition does not include vehicles subject to the provisions of Chapters 18 or 18a, Article III, or Section~~Sections~~ 7-609, 12-606, or 12-707.01 of the Illinois Vehicle Code; vehicle required to file proof of liability insurance with the Illinois Commerce Commission; vehicles covered by a certificate of self insurance pursuant to Section 7-502 of the Illinois Vehicle Code; vehicles owned by the United States Government, State of Illinois, or any political sub-division, municipality or local mass transit district; implements of husbandry, other vehicles complying with laws which require insurance in amounts meeting or exceeding the minimum amounts required under the Illinois Vehicle Code; and inoperable or stored vehicles that are not operated.

"Motorcycle" – every motor vehicle having a seat or saddle for use of the rider and designed to travel on not more than three wheels in contact with the ground, but excluding a tractor.

"Pedalcycle" – motor driven cycle whose speed attainable in 1 mile is 30 miles per hour or less, which is equipped with a motor that produces 2 brake horse

power or less.

"Proof of Insurance" –

Illinois insurance card [625 ILCS 5/7-602(a)];

the combination of proof of purchase of the motor vehicle within the previous 60 days and a current insurance card issued for the motor vehicle replaced by such purchase [625 ILCS 5/7-602(b)];

a current declarations page of a liability insurance policy [625 ILCS 5/7-602(c)];

liability insurance binder, certificate of liability insurance or receipt for payment to an insurer or its authorized representative for a liability insurance premium, provided such document contains all information the Secretary of State by rule or regulation may require [625 ILCS 5/7-602(d)];

a current rental agreement [625 ILCS 5/7-602(e)];

registration plates, registration sticker or other evidence of registration issued by the Secretary only upon submission of proof of liability insurance [625 ILCS 5/7-602(f)]; *or*

a certificate, decal, or other document or device issued by a governmental agency for a motor vehicle indicating the vehicle is insured for liability [625 ILCS 5/7-602(g)] or has qualified for an exemption under the law.

"Registration sticker" – a device issued by the Secretary of State to be attached to a rear registration plate that will renew the registration and registration plate or plates for a pre-determined period of time.

"Religious Organization Bus" – any vehicle other than a vehicle of the First Division or a school bus, as defined in Section 1-182 of the Illinois Vehicle Code [625 ILCS 5/1-182], which is exclusively owned and operated by a religious organization and is used primarily in conducting the official activities of such organization.

"Second Division Vehicle" – vehicles that are designed for carrying more than 10 persons, those designed or used for living quarters, those vehicles that are designed for pulling or carrying property, freight or cargo, those motor vehicles of the First Division remodeled for use and used as motor vehicles of the Second Division , and those motor vehicles of the First Division used and registered as school buses.

"Secretary of State" – the Secretary of State of Illinois.

"Senior Citizen Transportation Vehicle" – any vehicle other than a vehicle of the First Division or a school bus, as defined in Section 1-182 of the Illinois Vehicle Code, that is exclusively owned and operated by a senior citizen organization and is used primarily in conducting the official activities of such organization.

b) An applicant, who is required to take the road test, as defined in Section 1030.85 of this Part, must provide a representative vehicle for the test. The vehicle will be safety inspected by an examiner prior to the road test. A vehicle that is not properly equipped or that does not have equipment in safe operating order will be rejected for use in the road test. The following equipment shall be safety inspected as required for the type of representative vehicles being used to administer the road test:

1) Registration plates shall be attached or affixed to the motor vehicle pursuant to Section 3-413 of the Illinois Vehicle Title and Registration Law of the Illinois Vehicle Code [625 ILCS 5/3-413]. The owner of a vehicle who does not have registration plates and/or a registration sticker shall present proper documentation, pursuant to Section 3-407 of the Illinois Vehicle Title and Registration Law of the Illinois Vehicle Code [625 ILCS 5/3-407], showing that proper registration has been applied for, prior to use of the vehicle for road test.

2) When lighted lamps are required pursuant to Section 12-201(b) of the Illinois Vehicle Equipment Law for the road test, motor vehicles shall have mounted, exhibit and operate such lamps pursuant to Sections 12-201, 12-202, 12-204, 12-205, 12-207, 12-208, 12-209, 12-210 and/or 12-215 of the Illinois Vehicle Equipment Law of the Illinois Vehicle Code [625 ILCS 5/12-201, 12-202, 12-204, 12-205, 12-207, 12-208, 12-209, 12-210 and/or 12-215]. A motorized pedalcycle must have mounted and display a lamp ~~lamp(s)~~ and reflector as required in Section 11-1507.1 of

the Illinois Rules of the Road of the Illinois Vehicle Code [625 ILCS 5/11-1507.1].

3) When windshield wipers are required pursuant to Section 12-503(d) of the Illinois Vehicle Equipment Law of the Illinois Vehicle Code [625 ILCS 5/12-503(d)], they must be in proper operating condition as defined in the same statute.

4) The horn must be in proper working order pursuant to Section 12-601 of the Illinois Vehicle Equipment Law of the Illinois Vehicle Code [625 ILCS 5/12-601]. Horns do not include a siren, whistle, or bell.

5) *No person shall drive a motor vehicle with any sign, poster, window application, reflective material or nonreflective material upon the front windshield, sidewings, or side windows immediately adjacent to each side of the driver which materially obstructs, obscures or impairs the view from both within or without the vehicle. No person shall drive a motor vehicle with any objects placed or suspended between the driver and the front windshield or rear window which materially obstructs the driver's view. No person shall drive a motor vehicle when the windshield, side or rear windows are in such defective condition or repair as to materially impair the driver's view to the front, side or rear. A vehicle equipped with an unobstructed rear view mirror will be deemed to be in compliance in the event the rear window of the vehicle is materially obscured*. [625 ILCS 5/12-503~~502~~]

6) No vehicle may be used for the road test if one or more tires are unsafe as defined in Section 12-405 of the Illinois Vehicle Equipment Law of the Illinois Vehicle Code [625 ILCS 5/12-405]. A vehicle equipped with metal studded tires may not be used for the road test.

7) The service brakes, foot or hand operated, must be in a condition which allows activation with one movement of the activating device. All First and Second Division vehicles must be equipped with an operable emergency brake. A Class M motorcycle shall have two methods of braking. A Class L motor-driven cycle or pedalcycle shall have at least one method of braking.

8) Each driver and front seat passenger of a 1965 or later model motor

vehicle operated on a street or highway in this State~~state~~ shall wear a properly adjusted and fastened seat safety belt pursuant to Section 12-603.1 of the Illinois Vehicle Equipment Law of the Illinois Vehicle Code [625 ILCS 5/12-603.1]. Such requirements shall not apply to a driver possessing a written statement from a physician that such a person is unable, for medical or physical reasons, to wear a seat safety belt, or to certain motor vehicles that are not required to be equipped with seat safety belts under Federal Law (49 CFR 393.93). A retractable lap seat belt shall be provided for the driver of a school bus and must be used by the driver at all times while the bus is being operated, as required by Section 12-807 of the Illinois Vehicle Equipment Law of the Illinois Vehicle Code [625 ILCS 5/12-807].

9) Every motor vehicle shall be equipped with a mirror so located as to reflect to the driver a view of the highway for a distance of at least 200 feet to the rear of such motor vehicle. A rectangular rearview mirror shall be located on the right and left sides of each Second Division school bus forward of the driver's seat. The mirrors shall have a minimum horizontal dimension of 5 inches and a minimum vertical dimension of 10 inches.

10) The seat for the person giving the examination must be securely affixed in a location that assures the examiner's safety and allows the examiner to perform proper scoring of the road test pursuant to Section 1030.85 of this Part. The seat must be free from excessive soil, grease, and should have no protruding springs. Vehicles must not have loose objects on the seats or floors which could pose a danger to the driver or examiner.

11) The steering wheel must not be broken or have any part missing. The steering wheel when worked back and forth shall not have more than 5-10 degrees of free play (approximately 2" at the rim of a 20" steering wheel). Vehicles that have excessive free play (more than 10 degrees) in the steering mechanism shall be rejected as unsafe. Free play is the degree of movement the steering wheel must have before the front wheels move.

12) Both front vehicle doors must be operable from the inside and outside of the vehicle with the standard latching mechanism. Doors may not be wired or strapped shut.

13) Every motor vehicle of a width or design which would not allow hand

signals to be adequately visible from the front and rear, shall be equipped with an electric turn signal device that indicates the intention of the driver to turn to the right or to the left. Such signaling device shall be in the form of flashing red or amber lights located at the rear of the vehicle on the side toward which the turn is to be made, mounted on the same level and as widely spaced laterally as practicable. Turn signal lamps must be visible from a distance of not less than 300 feet in normal sunlight.

14) Any motor vehicle or combination vehicle that operates with air brakes must have air brake hoses that are free from breaks, leaks or bulges that may prevent or hinder the safe operation of the vehicle braking system. Any motor vehicle or combination vehicle that operates with air brakes will not be permitted to be used for the road test if the air pressure gauge ~~guage~~ reading fails to maintain 95 pounds per square inch pressure during normal pressure buildup.

15) Three safety flags, flares, fuses or reflectors shall be provided in all Second Division vehicles as described in Section 12-702 of the Illinois Vehicle Equipment Law of the Illinois Vehicle Code [625 ILCS 5/12-702].

16) An operating speedometer shall be mounted in all vehicles designated as a school bus in such a manner that it is readable to the seated driver.

17) The emergency doors at the front and the rear of a designated school bus should open from the inside. The latch must be in operable condition. An alarm system that is visible and audible to the driver must be activated when the engine is running and the emergency door is unlatched.

18) One fire extinguisher shall be located in a position readily accessible to the driver of a school bus pursuant to Section 12-808 of the Illinois Vehicle Equipment Law of the Illinois Vehicle Code [625 ILCS 5/12-808].

19) A school bus shall carry a removable and readily identifiable first aid kit, mounted in full view of and readily accessible to the driver pursuant to Section 12-809 of the Illinois Vehicle Equipment Law of the Illinois Vehicle Code [625 ILCS 5/12-809].

20) All school buses shall be equipped with an 8-lamp flashing signal system

consisting of two alternately flashing red signal lights and two flashing yellow signal lights mounted at the front and rear of the bus pursuant to Section 12-805 of the Illinois Vehicle Equipment Law of the Illinois Vehicle Code [625 ILCS 5/12-805]. Each signal lamp shall be a sealed beam at least 5½ inches in diameter and shall have sufficient intensity to be visible at 500 feet in normal sunlight. The system shall be actuated only by means of a manual switch. There shall be a device for indicating to the driver that the system is operating properly or is inoperative.

21) All Second Division vehicles, as required by Section 12-202 of the Illinois Vehicle Equipment Law of the Illinois Vehicle Code [625 ILCS 5/12-202], shall have mounted and properly display clearance, identification and side marker lamps. Such lamps shall be illuminated for the road test, during periods when headlamps are required pursuant to Section 12-201 of the Illinois Vehicle Equipment Law of the Illinois Vehicle Code [625 ILCS 5/12-201].

22) A stop arm shall be placed on the driver's side of each Second Division school bus and may be operated either manually or mechanically. The design of this stop arm shall comply with Section 12-803 of the Illinois Vehicle Equipment Law of the Illinois Vehicle Code [625 ILCS 5/12-803].

23) The tailpipes~~tailpipe(s)~~ of each Second Division school bus should extend beyond the rear end of the chassis frame, but not beyond the rear of the bumper.

24) A religious organization bus or senior citizen transportation vehicle may be of any color and have any markings designating its purpose other than those required for school buses pursuant to Sections 12-801, 12-802, 12-804 and 12-806 of the Illinois Vehicle Equipment Law of the Illinois Vehicle Code [625 ILCS 5/12-801, 12-802, 12-804 and 12-806]. A road test, for a religious organization bus or senior citizen transportation vehicle restriction, may be administered in any vehicle of the proper representative type for the license restriction requested (see 92 Ill. Adm. Code 1030.92).

25) No person shall operate any motorcycle, motor-driven cycle or pedalcycle for the road test with handlebars higher than the height of the shoulders of

the operator when seated in the upright driving position.

26) The operator of a motorcycle, motor-driven cycle or pedalcycle, used for the road test shall be protected by glasses, goggles or a transparent shield pursuant to Section 11-1404 of the Illinois Rules of the Road of the Illinois Vehicle Code [625 ILCS 5/11-1404].

27) Second Division vehicles or medical transport vehicles shall display a certificate of safety then in effect pursuant to Sections 13-111 and 13-114 of the Illinois Vehicle Inspection Law of the Illinois Vehicle Code [625 ILCS 5/13-111 and 13-114], except those vehicles displaying a Department of Transportation federal census number on the side of the vehicle shall not be subject to such certificate.

c) Prior to taking a road test, as defined in Section 1030.85 of this Part, each applicant shall execute an affirmation stating that the vehicle to be used for the road test:

1) Is~~is~~ insured pursuant to, and in compliance with, the Illinois Mandatory Insurance Law of the Illinois Vehicle Code [625 ILCS 5/Ch. 7, Art. VI] (the applicant shall provide proof of insurance); or

2) Falls~~falls~~ within one of the stated exempted categories.

d) If the applicant refuses to execute or fails to comply with this Section, then no road test shall be given the applicant in that vehicle until such time as the applicant complies.

(Source: Amended at 31 Ill. Reg. 11342, effective July 18, 2007)

SECRETARY OF STATE

NOTICE OF ADOPTED AMENDMENT

1) Heading of the Part: Cancellation, Revocation or Suspension of Licenses or Permits

2) Code Citation: 92 Ill. Admin. Code 1040

3)

Section Number:	Adopted Action:
1040.50	Amendment

4) Statutory Authority: [625 ILCS 5/2-104]; [625 ILCS 5/6-521]

5) Effective Date of Amendment: July 19, 2007

6) Does this rulemaking contain an automatic repeal date? No

7) Does this rulemaking contain incorporations by reference? No

8) A copy of the adopted amendment, including any material incorporated by reference, is on file in the agency's principal office and is available for public inspection.

9) Notice of Proposed Published in Illinois Register: 31 Ill. Reg. 6353; April 27, 2007

10) Has JCAR issued a Statement of Objection to this Amendment? No

11) Differences between proposal and final version: Throughout the text, JCAR added the word "Driving" after the word "Occupational." Other technical and grammatical, non-substantive changes were made as suggested by JCAR.

12) Have all the changes agreed upon by the agency and JCAR been made as indicated in the agreement letter issued by JCAR? Yes

13) Will this amendment replace any emergency amendment currently in effect? No

14) Are there any amendments pending on this Part? Yes

Section Number:	Proposed Action:	Illinois Register Citation:
1040.60	Amendment	31 Ill. Reg. 8895; June 14, 2007

15) Summary of Purpose of Amendment: Amends suspension of license of commercial motor vehicle driver. This amendment is necessary in order to come into compliance with the Federal Motor Carrier Safety Regulations.

SECRETARY OF STATE

NOTICE OF ADOPTED AMENDMENT

16) Information and questions regarding this adopted amendment shall be directed to:

Arlene J. Pulley
Office of the Secretary of State
Driver Services Department
2701 South Dirksen Parkway
Springfield, Illinois 62723

217-557-4462

The full text of the Adopted Amendment begins on the next page:

SECRETARY OF STATE

NOTICE OF ADOPTED AMENDMENT

TITLE 92: TRANSPORTATION
CHAPTER II: SECRETARY OF STATE

PART 1040
CANCELLATION, REVOCATION OR SUSPENSION
OF LICENSES OR PERMITS

Section

1040.10 Court to Forward Licenses and Reports of Convictions
1040.20 Illinois Offense Table
1040.25 Suspension or Revocation for Driving Without a Valid Driver's License
1040.29 2 or More Traffic Offenses Committed Within~~within~~ 24 Months by a Person Under the Age of 21 Years
1040.30 3 Or~~or~~ More Traffic Offenses Committed Within 12 Months
1040.31 Operating a Motor Vehicle During a Period of Suspension or Revocation
1040.32 Suspension or Revocation of Driver's Licenses, Permits or Identification Cards Used Fraudulently
1040.33 Suspension or Revocation of Driver's Licenses/Permits for Fictitious or Unlawfully Altered Disability License Plate or Parking Decal or Device or Fraudulent Disability License Plate or Parking Decal or Device
1040.35 Administrative Revocation for Commission of an Offense Requiring Mandatory Revocation Upon Conviction, and Suspension or Revocation Based Upon a Local Ordinance Conviction
1040.36 Suspension for Violation of Restrictions on Driver's License
1040.37 Suspension for Violation of Restrictions on Instruction Permit
1040.38 Commission of a Traffic Offense in Another State
1040.40 Repeated Convictions or Collisions
1040.41 Suspension of Licenses for Curfew Violations
1040.42 Fleeing and Eluding
1040.43 Illegal Transportation
1040.46 Fatal Accident and Personal Injury Suspensions or Revocations
1040.48 Vehicle Emission Suspensions
1040.50 Occupational Driving Permit~~Suspension or Revocation of License of Commercial Vehicle Driver~~
1040.52 Driver Remedial Education Course
1040.55 Suspension or Revocation for Driver's License Classification Violations
1040.60 Release of Information Regarding a Disposition of Court Supervision
1040.65 Offenses Occurring on Military Bases
1040.66 Invalidation of a Restricted Driving Permit

SECRETARY OF STATE

NOTICE OF ADOPTED AMENDMENT

1040.70	Problem Driver Pointer System
1040.80	Cancellation of Driver's License Upon Issuance of a Handicapped Identification Card
1040.100	Rescissions
1040.101	Reinstatement Fees
1040.102	Bankruptcy Rule for Suspensions, Cancellations, Failure to Pay and Returned Checks Actions
1040.105	Suspension for 5 or More Tollway Violations and/or Evasions
1040.107	Suspension for Violation of 625 ILCS 5/11-907, Approaching a Stationary Emergency Vehicle
1040.108	Suspension for Failure to Make Report of Vehicle Accident Violations
1040.109	Two or More Convictions for Railroad Crossing Violations
1040.110	Bribery
1040.111	Suspension for Violation of 625 ILCS 5/11-908(a-1) for Failure to Yield upon Entering a Construction or Maintenance Zone when~~When~~ Workers Are Present
1040.115	Suspension for Theft of Motor Fuel

AUTHORITY: Implementing Articles II and VII of the Illinois Driver Licensing Law of the Illinois Vehicle Code [625 ILCS 5/Ch. 6, Arts. II and VII] and authorized by Section 2-104(b) of the Illinois Vehicle Title and Registration Law of the Illinois Vehicle Code [625 ILCS 5/2-104(b)].

SOURCE: Filed September 22, 1972; amended at 3 Ill. Reg. 26, p. 282, effective June 30, 1979; amended at 5 Ill. Reg. 3533, effective April 1, 1981; amended at 6 Ill. Reg. 4239, effective April 2, 1982; codified at 6 Ill. Reg. 12674; amended at 8 Ill. Reg. 2200, effective February 1, 1984; amended at 8 Ill. Reg. 3783, effective March 13, 1984; amended at 8 Ill. Reg. 18925, effective September 25, 1984; amended at 8 Ill. Reg. 23385, effective November 21, 1984; amended at 10 Ill. Reg. 15265, effective September 4, 1986; amended at 11 Ill. Reg. 16977, effective October 1, 1987; amended at 11 Ill. Reg. 20659, effective December 8, 1987; amended at 12 Ill. Reg. 2148, effective January 11, 1988; amended at 12 Ill. Reg. 14351, effective September 1, 1988; amended at 12 Ill. Reg. 15625, effective September 15, 1988; amended at 12 Ill. Reg. 16153, effective September 15, 1988; amended at 12 Ill. Reg. 16906, effective October 1, 1988; amended at 12 Ill. Reg. 17120, effective October 1, 1988; amended at 13 Ill. Reg. 1593, effective January 23, 1989; amended at 13 Ill. Reg. 5162, effective April 1, 1989; amended at 13 Ill. Reg. 7802, effective May 15, 1989; amended at 13 Ill. Reg. 8659, effective June 2, 1989; amended at 13 Ill. Reg. 17087, effective October 16, 1989; amended at 13 Ill. Reg. 20127, effective December 8, 1989; amended at 14 Ill. Reg. 2944, effective February 7, 1990; amended at 14 Ill. Reg. 3664, effective February 7, 1990; amended at 14 Ill. Reg. 5178, effective April 1, 1990; amended at 14 Ill. Reg. 5560, effective March 22, 1990; amended at 14 Ill. Reg. 14177, effective

August 21, 1990; amended at 14 Ill. Reg. 18088, effective October 22, 1990; amended at 15 Ill. Reg. 14258, effective September 24, 1991; amended at 17 Ill. Reg. 8512, effective May 27, 1993; amended at 17 Ill. Reg. 9028, effective June 2, 1993; amended at 17 Ill. Reg. 12782, effective July 21, 1993; amended at 18 Ill. Reg. 7447, effective May 3, 1994; amended at 18 Ill. Reg. 10853, effective June 27, 1994; amended at 18 Ill. Reg. 11644, effective July 7, 1994; amended at 18 Ill. Reg. 16443, effective October 24, 1994; amended at 20 Ill. Reg. 2558, effective January 26, 1996; amended at 21 Ill. Reg. 8398, effective June 30, 1997; amended at 21 Ill. Reg. 10985, effective July 29, 1997; amended at 21 Ill. Reg. 12249, effective August 26, 1997; amended at 21 Ill. Reg. 12609, effective August 29, 1997; amended at 22 Ill. Reg. 1438, effective January 1, 1998; amended at 22 Ill. Reg. 5083, effective February 26, 1998; amended at 22 Ill. Reg. 13834, effective July 10, 1998; amended at 24 Ill. Reg. 1655, effective January 11, 2000; emergency amendment at 24 Ill. Reg. 8398, effective June 2, 2000, for a maximum of 150 days; emergency expired October 29, 2000; emergency amendment at 24 Ill. Reg. 16096, effective October 12, 2000, for a maximum of 150 days; amended at 24 Ill. Reg. 16689, effective October 30, 2000; amended at 25 Ill. Reg. 2723, effective January 31, 2001; amended at 25 Ill. Reg. 6402, effective April 26, 2001; emergency amendment at 26 Ill. Reg. 2044, effective February 1, 2002, for a maximum of 150 days; emergency expired June 30, 2002; emergency amendment at 26 Ill. Reg. 3753, effective February 21, 2002, for a maximum of 150 days; emergency expired July 20, 2002; amended at 26 Ill. Reg. 12373, effective July 25, 2002; amended at 26 Ill. Reg. 13684, effective August 28, 2002; amended at 29 Ill. Reg. 2441, effective January 25, 2005; amended at 29 Ill. Reg. 13892, effective September 1, 2005; amended at 29 Ill. Reg. 15968, effective October 7, 2005; amended at 1896, effective January 26, 2006; amended at 30 Ill. Reg. 2557, effective February 10, 2006; amended at 30 Ill. Reg. 11299, effective June 12, 2006; amended at 31 Ill. Reg. 4792, effective March 12, 2007; amended at 31 Ill. Reg. 5647, effective March 20, 2007; amended at 31 Ill. Reg. 7296, effective May 3, 2007; amended at 31 Ill. Reg. 7656, effective May 21, 2007; amended at 31 Ill. Reg. 11356, effective July 19, 2007.

Section 1040.50 Occupational Driving Permit~~Suspension or Revocation of License of Commercial Vehicle Driver~~

a) For purposes of this Section, the following definitions shall apply:

"Cancellation" – the annulment or termination by formal action of the Secretary of a person's driver's license because the licensee is no longer entitled to that~~such~~ license in accordance with Section 1-110 of the Illinois Vehicle Code and Sections 6-201 and 6-206(c)(3) of the Illinois Driver Licensing Law of the Illinois Vehicle Code [625 ILCS 5/1-110, 6-201 and 6-206(c)(3)].

"Commercial Driver's License" or "CDL" - a license issued by a state or other jurisdiction, in accordance with the standards contained in 49 CFR 383, to an individual that authorizes the individual to operate a class of a commercial motor vehicle.

"Commercial Motor Vehicle" or "CMV" – a motor vehicle, used in commerce, except those referred to in Section 6-500(6)(B) of the Illinois Vehicle Code, designed to transport passengers or property if:

the vehicle has a Gross Vehicle Weight Rating (GVWR) of 26,001 pounds or more or such a lesser GVWR as subsequently determined by federal regulations (49 CFR 383); or

any combination of vehicles with a Gross Combination Weight Rating (GCWR) of 26,001 pounds or more, provided the GVWR of any vehicle or vehicles being towed is 10,001 pounds or more; or

a vehicle designed to transport 16 persons; or

a vehicle transporting hazardous materials and that is required to be placarded in accordance with 49 CFR 172, subpart F.

"Commercial Vehicle" – any vehicle operated for the transportation of persons or property in the furtherance of any commercial or industrial enterprise, for-hire or not-for-hire, but not including a commuter van, a vehicle used in a ridesharing arrangement when being used for that purpose, or a recreational vehicle not being used commercially.

"Disqualification" – the suspension, revocation, or cancellation of a CDL by the state or jurisdiction of issuance; any withdrawal of a person's privileges to drive a commercial motor vehicle by a state or other jurisdiction as a result of a violation of state or local law relating to motor vehicle traffic control (other than parking, vehicle weight or vehicle defect violations); a determination by the Federal Motor Carrier Safety Administration that a person is not qualified to operate a commercial vehicle under 49 CFR 391~~a withdrawal of the privilege to drive a commercial motor vehicle~~.

"Driver Improvement Course" – an organized remedial activity approved by the Driver Services Department for improving the driving habits of certain suspended

drivers. This course shall consist of individual counseling and/or group sessions of instruction and shall not exceed 2 sessions or a total of 9 hours of instruction.

"Farm Vehicle" – every motor vehicle designed and used primarily as a farm implement for drawing wagons, plows, mowing machines and other implements of husbandry, and every implement of husbandry that~~which~~ is self-propelled, excluding all-terrain vehicles and off-highway motorcycles.

"Hearing Officer" – any person designated by the Secretary of State to preside at any hearing conducted pursuant to the rules established by the Office of the Secretary of State (92 Ill. Adm. Code 1001).

"Implement of Husbandry" – every vehicle designed and adapted exclusively for agricultural, horticultural, or livestock raising operations, including farm wagons, wagon trailers or like vehicles used in connection therewith, or for lifting or carrying an implement of husbandry, provided that no farm wagon, wagon trailer or like vehicle having a gross weight of more than 36,000 pounds shall be included hereunder.

"Occupational Driving Permit~~Restricted Driving Permit for Occupational Driving~~" – ~~a restricted driving permit is~~ the ~~that~~ document that~~which~~ grants and specifies limited privileges to drivers of commercial vehicles as an occupation who have had their full driving privileges suspended. The occupational driving permit~~restricted driving permit~~ is valid only when in the immediate possession of the driver to whom it is issued.

"Revocation" – the termination by formal action of the Secretary of a person's license or privilege to operate a motor vehicle on the public highways, which termination shall not be subject to renewal or restoration, except that an application for a new license may be presented and acted upon by the Secretary after the expiration of at least 1 year after the date of revocation.

"Secretary of State" – the Secretary of State of Illinois.

"Suspension" – the temporary withdrawal by formal action of the Secretary of a person's license or privilege to operate a motor vehicle on public highways, for a period specifically designated by the Secretary.

b) If the Secretary of State suspends the driver's license of a person under Section 6-

206(a)(2) of the Illinois Vehicle Code [625 ILCS 5/6-206(a)(2)] and the person drives a commercial vehicle in connection with his/her regular occupation, he/she may qualify for an occupational driving permit~~a Restricted Driving Permit for Occupational Driving~~ based on the following requirements:

1) 18 years of age;

2) the individual must have been issued or have qualified for a valid Illinois driver's license prior to issuance of the occupational driving permit~~Restricted Driving Permit for Occupational Driving~~;

3) no outstanding reinstatement fees or failure to pay requirements are effective on the Illinois driving record;

4) no effective or pending suspensions, revocations, cancellations or disqualifications on the individual's Illinois driving record;

5) the suspension period does not exceed 12 months;

6) the suspension was the result of 3, 4 or 5 offenses that~~which~~ were committed within a 12 month period. If 5 offenses were committed, at least 2 of that~~which~~ occurred while operating a commercial vehicle in connection with the driver's regular occupation, the driver would not qualify for an occupational driving permit~~a Restricted Driving Permit for Occupational Driving~~;

7) the individual's occupation must be full time, and one that~~which~~ involves driving a commercial vehicle on a regular basis. Part-time employment or a person renting a commercial vehicle under a short term lease shall not qualify;

8) the individual must successfully complete a Driver Improvement Course prior to the issuance of the occupational driving permit~~Restricted Driving Permit for Occupational Driving~~;

9) the individual shall complete and sign an affidavit prescribed by the Secretary of State setting forth his/her eligibility as a driver of a commercial vehicle and such other information as required by the Secretary of State. The affidavit shall also be notarized by a Notary Public

or signed by a Secretary of State Hearing Officer;

10) the individual must submit a notarized letter from the employer, on the employer's letterhead, verifying employment;

11) submit appropriate fee;

12) surrender current valid Illinois driver's license.

c) Operation of the following vehicles shall not be deemed to be the operation of a commercial vehicle:

1) farm~~Farm~~ vehicle;

2) implements~~Implements~~ of husbandry;

3) road~~Road~~ machinery temporarily on the highway;

4) a~~A~~ farm tractor being operated between the home farm and adjacent or nearby farm.

d) If the permit holder's regular occupation changes, or if the original permit is lost or stolen, the driver is required to apply for a corrected or duplicate permit in order to continue driving. The driver must qualify by meeting the requirements outlined in subsection (b) of this Section and shall submit an affidavit verifying the lost or stolen permit in order to be issued a duplicate permit, or surrender the original permit to obtain a corrected permit.

e) Upon receipt by this Office of the 5th conviction within a 12 month period, if at least 2 of the convictions were issued for violations committed in his/her commercial vehicle, or a 6th conviction within a 12 month period was received and the permit was still valid, an Order of Cancellation shall be entered pursuant to Section 6-206(c)(3) of the Illinois Vehicle Code [625 ILCS 5/6-206(c)(3)].

f) An occupational driving permit~~A Restricted Driving Permit for Occupational Driving~~ shall be cancelled if the Secretary of State receives reliable written evidence that the individual does not qualify for the permit as outlined in subsection (b) of this Section.

g) Any driver required to obtain a commercial driver's license under Section 6-507 [625 ILCS 5/6-507] may not be issued an occupational driving permit to operate a commercial motor vehicle while the individual's CDL is cancelled, revoked, suspended or disqualified under Sections 6-507(b) and 6-514 [625 ILCS 5/6-507(b) and 6-514].~~This permit shall not apply to any driver required to obtain a commercial driver's license under Section 6-507 during the period of a disqualification of commercial driving privileges under Section 6-514 [625 ILCS 5/6-507 and 6-514].~~

h) Any person who falsely states any fact in the affidavit required by subsection (b)(9)~~herein~~ shall be guilty of perjury under Section 6-302 of the Vehicle Code [625 ILCS 5/6-302] and upon conviction ~~thereof~~ shall have all driving privileges revoked without further rights.

(Source: Amended at 31 Ill. Reg. 11356, effective July 19, 2007)

DEPARTMENT OF TRANSPORTATION

NOTICE OF ADOPTED AMENDMENTS

1) Heading of the Part: Request for Public Records

2) Code Citation: 2 Ill. Adm. Code 1226

3)

Section Numbers:	Adopted Action:
1226.110	Amend
1226.430	Amend
1226.APPENDIX B	Amend

4) Statutory Authority: Implementing and authorized by the Freedom of Information Act [5 ILCS 140]; Section 5-15 of the Illinois Administrative Procedure Act [5 ILCS 100/5-15]; and also authorized by Section 16 of the Civil Administrative Code of Illinois [20 ILCS 5/16]

5) Effective Date of Amendments: July 17, 2007

6) Does this rulemaking contain an automatic repeal date? No

7) Does this rulemaking contain incorporations by reference? No

8) A copy of the adopted amendments, is on file in the Department's Office of Chief Counsel, and is available for public inspection.

9) Notice of Proposal Published in Illinois Register: Publication of proposed amendments is not applicable as prescribed by Section 5-15 of the Illinois Administrative Procedure Act [5 ILCS 100/5-15].

10) Has JCAR issued a Statement of Objection to this rulemaking? No

11) Differences between proposal and final version: Not Applicable

12) Have all the changes agreed upon by the Agency and JCAR been made as indicated in the agreements issued by JCAR? Not Applicable

13) Will these amendments replace any emergency amendments currently in effect? No

14) Are there any amendments pending on this Part? No

DEPARTMENT OF TRANSPORTATION

NOTICE OF ADOPTED AMENDMENTS

15) Summary and Purpose of Amendments: By this Notice, the Department has amended this Part to update information regarding the submission of a request for public records. Requests should now be sent to the Office of Chief Counsel rather than the Director of Public Affairs.

16) Information and questions regarding these adopted amendments shall be directed to:

Ms. Barbara Brush, FOIA Coordinator
Illinois Department of Transportation
Office of Chief Counsel, Room 300
Springfield, Illinois 62764

217/785-2965

The full text of the Adopted Amendments begins on the next page:

DEPARTMENT OF TRANSPORTATION

NOTICE OF ADOPTED AMENDMENTS

TITLE 2: GOVERNMENTAL ORGANIZATION
SUBTITLE D: CODE DEPARTMENTS
CHAPTER XXII: DEPARTMENT OF TRANSPORTATION

PART 1226
REQUEST FOR PUBLIC RECORDS

SUBPART A: INTRODUCTION

Section
1226.10 Summary and Purpose
1226.20 Definitions

SUBPART B: PROCEDURES FOR REQUESTING PUBLIC RECORDS

Section
1226.110 Submission of Request
1226.120 Form and Content of Requests

SUBPART C: PROCEDURES FOR DEPARTMENT RESPONSE
TO REQUESTS FOR PUBLIC RECORDS

Section
1226.210 Timeline for Department Response
1226.220 Types of Department Responses

SUBPART D: PROCEDURES FOR APPEAL OF A DENIAL

Section
1226.310 Appeal of a Denial
1226.320 Secretary's Response to Appeal
1226.330 Delegation by Secretary

SUBPART E: PROCEDURES FOR PROVIDING
PUBLIC RECORDS TO REQUESTERS

Section
1226.410 Inspection of Records at Department Offices
1226.420 Copies of Public Records

DEPARTMENT OF TRANSPORTATION

NOTICE OF ADOPTED AMENDMENTS

1226.430 Materials Available Under Section 4 of FOIA

1226.APPENDIX A Request for Public Records
1226.APPENDIX B Fee Schedule for Duplication of Public Records

AUTHORITY: Implementing and authorized by the Freedom of Information Act [5 ILCS 140]; Section 5-15 of the Illinois Administrative Procedure Act [5 ILCS 100/5-15]; and Section 16 of the Civil Administrative Code of Illinois [20 ILCS 5/16].

SOURCE: Adopted and codified at 8 Ill. Reg. 12526, effective July 1, 1984; amended at 19 Ill. Reg. 1334, effective January 31, 1995; amended at 31 Ill. Reg. 11366, effective July 17, 2007.

SUBPART B: PROCEDURES FOR REQUESTING PUBLIC RECORDS

Section 1226.110 Submission of Request

a) Person To Whom Requests are Submitted

1) A request for records other than records maintained by a District highway office shall be sent to:

Office of Chief Counsel~~Director of Public Affairs~~
Room 300
2300 South Dirksen Parkway
Springfield, Illinois 62764

2) A request for records maintained by a District highway office shall be sent to the District Engineer for the District. The addresses of the District highway offices are as follows:

District 1

201 West Center Court
Schaumburg, IL 60196-1096~~60194~~

District 2

819 Depot Avenue
Dixon, IL 61021-3546

DEPARTMENT OF TRANSPORTATION

NOTICE OF ADOPTED AMENDMENTS

District 3

700 East Norris Drive
Box 697
Ottawa, IL 61350-0697

District 4

401 Main Street
Peoria, IL 61602-1111

District 5

13473 IL Hwy. 133~~Route 133, West~~, P.O. Box 610
Paris, IL 61944-0610

District 6

126 East Ash Street
Springfield, IL 62704-4792

District 7

400 West Wabash~~State Transportation Building~~
Effingham, IL 62401-2699

District 8

1100 East Port Plaza Drive
Collinsville, IL 62234-6198

District 9

State Transportation Building
P. O. Box 100
Carbondale, IL 62903-0100

b) Requests for records other than records maintained by a District highway office

which are sent to a District highway office may be returned as improperly submitted. If a person making a request is unsure where the requested records are maintained, the request should be sent to the Office of Chief Counsel~~Director of Public Affairs~~ at the address in subsection (a)(1) of this Section.

c) An envelope containing a request for records shall be plainly marked "REQUEST FOR RECORDS". Failure to so mark the envelope may delay processing.

d) Requests for records which are not submitted to the Office of Chief Counsel~~Director of Public Affairs~~ or to District Engineers as provided in this Section will be handled expeditiously. However, the required response times contained in the FOIA and this Part do not apply to requests which are not submitted as provided in this Section.

(Source: Amended at 31 Ill. Reg. 11366, effective July 17, 2007)

SUBPART E: PROCEDURES FOR PROVIDING PUBLIC RECORDS TO REQUESTORS

Section 1226.430 Materials Available Under Section 4 of FOIA

The Office of Chief Counsel~~Director of Public Affairs~~ and the District Engineers shall make available to the public for inspection and copying at no charge and shall send through the mail if requested the following materials:

a) A brief description of the organizational structure and budget of the Department; and

b) A brief description of the means for requesting information and public records including the "Fee Schedule for Duplication of Public Records."

(Source: Amended at 31 Ill. Reg. 11366, effective July 17, 2007)

DEPARTMENT OF TRANSPORTATION

NOTICE OF ADOPTED AMENDMENTS

Section 1226.APPENDIX B Fee Schedule for Duplication of Public Records

Type of Duplication	Charge
Paper copy from paper original (not exceeding 8½ inches x 14 inches)	$ .10
Paper copy from microfilm original (not exceeding 8½ inches x 14 inches)	.10
Microfilm from microfilm original	5.78
Computer printout	
Batch processing, per CPU Hour	615.00
Per tape mount	.95
Paper printout, per 1000 lines	.33
Black and white photograph (8 inches x 10 inches)	
From negative	4.00
From photograph	9.00
Color photograph (8 inches x 10 inches)	
From negative	5.50
Microfiche	
Paper	.08
Film	.75

The fee for certifying copies is $1.00 per request.

Charges for specially compiled bulletins, manuals, maps and other publications will be in accordance with Attachment 2 to "Illinois Department of Transportation Statements Under Sections 4 and 5 of the Freedom of Information Act," copies of which are available from the Office of Chief Counsel~~Director of Public Affairs~~ and the District Engineers. See Section 1226.110 for addresses.

The fee for a specially made copy or any other copy not otherwise provided for shall be the actual cost of reproduction.

(Source: Amended at 31 Ill. Reg. 11366, effective July 17, 2007)

ILLINOIS BOARD OF EXAMINERS

NOTICE OF EMERGENCY AMENDMENT

1) Heading of the Part: Certificate of Certified Public Accountant

2) Code Citation: 23 Ill. Adm. Code 1400

3) Section Number: 1400.90 — Emergency Action: Amendment

4) Statutory Authority: Authorized by Section 3 of the Illinois Public Accounting Act [225 ILCS 450/3]

5) Effective Date of Amendment: July 27, 2007

6) If this emergency rulemaking is to expire before the end of the 150-day period, please specify the date on which it is to expire: The emergency rulemaking will expire at the end of the 150-day period, or upon adoption of permanent rules, whichever comes first.

7) Date Filed with the Index Department: July 18, 2007

8) A copy of the emergency amendment, including any material incorporated by reference, is on file in the agency's principal office and is available for public inspection.

9) Reason for Emergency: In April 2004, the Uniform CPA exam changed from a paper and pencil exam administered twice a year over two days to a computer-based testing format offered each calendar quarter for eight weeks. At that time, the Illinois Board of Examiners believed that more frequent testing opportunities eliminated the need for candidates to be provisionally approved to test while completing their academic studies to qualify to test. Over the past three years it has become apparent that eliminating the provisional approval for first-time candidates has created undue hardship for those students wanting to complete the CPA exam before starting their professional careers. The number of persons completing the exam has diminished as a result. This emergency rule, which reinstates prior policy, is needed immediately to allow candidates to commence testing as soon as they are registered for their final semester of courses. It is important that this amendment be in effect for the fall 2007 academic term.

10) A Complete Description of the Subjects and Issues Involved: A change is being made to allow first-time candidates to qualify to take the CPA exam while registered in their final term of classes. There is no diminution of academic requirements to qualify for the CPA examination. Candidates will still be required to meet all current educational requirements as stated in the Illinois Public Accounting Act and the Rules Governing the

ILLINOIS BOARD OF EXAMINERS

NOTICE OF EMERGENCY AMENDMENT

Certificate of Certified Public Accounting. No exam scores will be released without receipt of final official documentation proving completion of all critical courses and/or degree requirements. Because there is no testing during one month of each quarter, the lack of provisional approval forces candidates to defer testing a minimum of three to six months after coursework is completed.

11) Are there any proposed rulemakings to this Part pending? No

12) Statement of Statewide Policy Objective: This rulemaking does not create or expand a State mandate.

13) Information and questions regarding this emergency rulemaking shall be directed to:

Joanne Vician
Executive Director
Board of Examiners
100 Trade Centre Drive
Suite 403
Champaign IL 61820

217-531-0929

The full text of the Emergency Amendment begins on the next page:

ILLINOIS BOARD OF EXAMINERS

NOTICE OF EMERGENCY AMENDMENT

TITLE 23: EDUCATION AND CULTURAL RESOURCES
SUBTITLE A: EDUCATION
CHAPTER VI: BOARD OF EXAMINERS

PART 1400
CERTIFICATE OF CERTIFIED PUBLIC ACCOUNTANT

Section

1400.10 Administrative Functions
1400.20 Duties of the Board of Examiners
1400.30 Appointment to the Board of Examiners
1400.40 Board Address
1400.50 Organization and Compensation of the Board of Examiners
1400.55 Admission to the Examination; Issuance of Reciprocal Certified Public Accountant Certificates
1400.60 Filing of the Application and Payment of Fees
1400.70 Rebate of Fees
1400.80 Appeals; Hearings
1400.90 The Educational Requirement
EMERGENCY
1400.100 Examinations - General
1400.105 Examinations - Misconduct
1400.110 Examinations - Uniform Examination - Non-Disclosure - Security
1400.115 Examinations - Required Confidentiality Statements
1400.116 Examinations - Violations
1400.117 Examinations - Penalties for Violation of Non-Disclosure Provisions
1400.120 Examinations - Frequency
1400.130 Examinations - Scope
1400.140 Examinations - Length
1400.150 Examinations - Preparations and Grading
1400.160 Grading Scale, Transitional Condition Candidates, Transfer of Credits, Reciprocity and Out-of-State Candidates
1400.170 Re-Examination
1400.175 Candidate Request for Scoring Review
1400.177 Required Exam on Rules of Professional Conduct
1400.180 Certified Public Accountant Certificate - Awarding
1400.190 Retention of Records
1400.200 Disposition of Fees
1400.210 Granting Variances

ILLINOIS BOARD OF EXAMINERS

NOTICE OF EMERGENCY AMENDMENT

AUTHORITY: Implementing and authorized by Section 26 of the Illinois Public Accounting Act [225 ILCS 450/26].

SOURCE: Emergency rule at 5 Ill. Reg. 276, effective December 15, 1980, for a maximum of 150 days; adopted at 5 Ill. Reg. 8303, effective July 31, 1981; emergency amendment at 7 Ill. Reg. 7342, effective June 1, 1983, for a maximum of 150 days; codified at 8 Ill. Reg. 3342; amended at 8 Ill. Reg. 24720, effective December 12, 1984; amended at 10 Ill. Reg. 4237, effective February 21, 1986; amended at 18 Ill. Reg. 14143, effective August 26, 1994; emergency amendment at 19 Ill. Reg. 984, effective January 18, 1995, for a maximum of 150 days; transferred from Chapter V, 23 Ill. Adm. Code 1300 (Board of Trustees) pursuant to 225 ILCS 450, January 1, 1994, at 19 Ill. Reg. 6325; amended at 20 Ill. Reg. 6262, effective May 1, 1996; amended at 21 Ill. Reg. 13315, effective September 26, 1997; amended at 28 Ill. Reg. 4548, effective March 5, 2004; emergency amendment at 28 Ill. Reg. 16485, effective December 17, 2004, for a maximum of 150 days; emergency expired May 15, 2005; amended at 29 Ill. Reg. 19524, effective November 21, 2005; emergency amendment at 31 Ill. Reg. 11373, effective July 27, 2007, for a maximum of 150 days.

Section 1400.90 The Educational Requirement
EMERGENCY

a) As provided in Section 3 of the Act, to be admitted to take the examination given before January 1, 2001, a candidate for the Illinois certified public accountant examination must have successfully completed at least 120 semester hours of acceptable credit. Of the semester hours accepted by the Board, at least 27 semester hours shall be in the study of accounting, auditing and business law, provided not more than 6 semester hours shall be in business law. Candidates may apply to take the certified public accountant examination during their final term, semester or quarter, but must meet the educational requirements at the time the examination is given.

b) Acceptable credit recognized by the Board is:

1) credit earned from a college or university which is a candidate for or is accredited by a regional accrediting association which is a member of the Commission on Recognition of Postsecondary Accreditation (CORPA),

2) credit earned at a business school or college of business within the educational institution that is accredited by the American Assembly of

Collegiate Schools of Business (AACSB), or

3) Association of Collegiate Business Schools and Programs (ACBSP).

c) To be admitted to take the examination for the first time after January 1, 2001, a candidate for the Illinois CPA examination must have successfully completed at least 150 semester hours of acceptable credit including a baccalaureate or higher degree. The semester hours accepted by the Board must include an accounting concentration or its equivalent. A candidate will be deemed to have met the education requirement if, as part of the 150 semester hours of education or equivalent as determined by the Board, he or she has met any one of the four conditions listed in subsections (c)(1) through (4). With each of the conditions listed, accounting hours do not include business law, and no more than six semester hours of accounting may be obtained through internships or life-experience.

1) Earned a graduate degree with a concentration in accounting from a program that is accredited in accounting by an accrediting agency recognized by the Board.

2) Earned a graduate degree from a program that is accredited in business by an accrediting agency recognized by the Board and completed at least 24 additional semester hours in accounting at the undergraduate level or 15 semester hours at the graduate level or equivalent combination thereof, including courses covering the subjects of financial accounting, auditing, taxation, and management accounting.

3) Earned a baccalaureate degree from a program that is accredited in business by an accrediting agency recognized by the Board and completed 24 semester hours in accounting at the undergraduate or graduate level, including courses covering the subjects of financial accounting, auditing, taxation, and management accounting, and completed at least 24 additional semester hours of business courses, or substantially equivalent (other than accounting) courses, at the undergraduate or graduate level.

4) Earned a baccalaureate or higher degree from an accredited educational institution or other institution recognized by the Board, including at least 24 semester hours of accounting at the undergraduate and/or graduate level with at least one course each in financial accounting, auditing,

taxation, and management accounting and completed at least 24 additional semester hours in business courses or substantially equivalent (other than accounting) courses at the undergraduate or graduate level.

d) For purposes of subsection (c), the formula for conversion of semester hours to quarter hours is 1 semester hour times 1.5 equals 1 quarter hour.

e) Authorization to Test

1) Except as otherwise provided in subsection (e)(2), proof of satisfactory completion of all educational requirements must be received by the Board before the Board issues an authorization to test.

2) First-time candidates whose exam applications are received in the Board office on or after August 15, 2007 may be granted provisional approval of in-progress courses taken at domestic institutions. Candidates granted provisional approval shall be allowed 120 days from the date of taking the first section of the examination to provide evidence that all requirements have been completed. No exam scores will be released to the candidate until all final official credential(s) are received and eligibility verified by board staff. If final transcripts verifying completion of all courses for eligibility to test are not received by the Board within 120 days after taking the first examination section of the CPA examination, scores for all examination sections authorized with provisional approval will be voided. If a candidate is not eligible after review of final credentials, scores for all examination sections authorized with provisional approval will be voided. Only one provisional Authorization to Test will be issued to a candidate.
~~First time candidates who apply for the examination prior to July 1, 2005 will be granted provisional approval of in-progress courses taken at domestic institutions. Candidates granted provisional approval shall be allowed 60 days from the date of taking the first section of the examination to provide evidence that all requirements have been completed. No grades will be released to the candidate until all final official credentials are received and eligibility verified by board staff. If final transcripts verifying completion of all courses for eligibility to sit are not received by the Board within 60 days after taking the first examination section of the computer-based examination, grades for all examination sections authorized with provisional approval will be voided.~~

ILLINOIS BOARD OF EXAMINERS

NOTICE OF EMERGENCY AMENDMENT

(Source: Amended by emergency rulemaking at 31 Ill. Reg. 11373, effective July 27, 2007, for a maximum of 150 days)

JOINT COMMITTEE ON ADMINISTRATIVE RULES
ILLINOIS GENERAL ASSEMBLY

SECOND NOTICES RECEIVED

The following second notices were received by the Joint Committee on Administrative Rules during the period of July 17, 2007 through July 23, 2007 and have been scheduled for review by the Committee at its August 14, 2007 meeting. Other items not contained in this published list may also be considered. Members of the public wishing to express their views with respect to a rulemaking should submit written comments to the Committee at the following address: Joint Committee on Administrative Rules, 700 Stratton Bldg., Springfield IL 62706.

Second Notice Expires	Agency and Rule	Start Of First Notice	JCAR Meeting
8/30/07	Department of Natural Resources, Commercial Fishing and Musseling in Certain Waters of the State (17 Ill. Adm. Code 830)	4/13/07 31 Ill. Reg. 5737	8/14/07
9/1/07	Department of Children and Family Services, Licensing Enforcement (89 Ill. Adm. Code 383)	3/23/07 31 Ill. Reg. 4511	8/14/07
9/1/07	Department of Children and Family Services, Licensing Enforcement (Repealer) (89 Ill. Adm. Code 383)	3/23/07 31 Ill. Reg. 4499	8/14/07
9/1/07	Department of Revenue, Property Tax Code (86 Ill. Adm. Code 110)	6/1/07 31 Ill. Reg. 7494	8/14/07
9/1/07	Department of Revenue, Retailers' Occupation Tax (86 Ill. Adm. Code 130)	6/1/07 31 Ill. Reg. 7504	8/14/07
9/2/07	Department of Revenue, Public List of Delinquent Taxpayers (86 Ill. Adm. Code 710)	6/1/07 31 Ill. Reg. 7519	8/14/07

DEPARTMENT OF REVENUE

NOTICE OF PUBLIC INFORMATION

2007 SECOND QUARTER INCOME TAX SUNSHINE INDEX

1. Statute requiring agency to publish information concerning Private Letter Rulings in the Illinois Register:

Name of Act: Illinois Department of Revenue Sunshine Act Citation: 20 ILCS 2515/1 et seq.

2. Summary of information:

Index of Department of Revenue income tax Private Letter Rulings and General Information Letters issued for the Second Quarter of 2007. Private letter rulings are issued by the Department in response to specific taxpayer inquiries concerning the application of a tax statute or rule to a particular fact situation. Private letter rulings are binding on the Department only as to the taxpayer who is the subject of the request for ruling. (See 2 Ill. Adm. Code 1200.110) General information letters are issued by the Department in response to written inquiries from taxpayers, taxpayer representatives, business, trade, industrial associations or similar groups. General information letters contain general discussions of tax principles or applications. General information letters are designed to provide general background information on topics of interest to taxpayers. General information letters do not constitute statements of agency policy that apply, interpret, or prescribe tax laws administered by the Department. *General information letters may not be relied upon by taxpayers in taking positions with reference to tax issues and create no rights for taxpayers under the Taxpayers' Bill of Rights Act.* (See 2 Ill. Adm. Code 1200.120)

The letters are listed numerically, are identified as either a General Information Letter or a Private Letter Ruling and are summarized with a brief synopsis under the following subjects:

Base Income
Bingo, Pull Tabs And Charitable Games
Credits – Foreign Tax
Deficiencies
Estimated Tax
Miscellaneous
Refunds
Withholding
Withholding – Other Rulings

Copies of the ruling letters themselves are available for inspection and may be purchased for a minimum of $1.00 per opinion plus 50 cents per page for each page over one.

DEPARTMENT OF REVENUE

NOTICE OF PUBLIC INFORMATION

2007 SECOND QUARTER INCOME TAX SUNSHINE INDEX

Copies of the ruling letters may be downloaded free of charge from the Department's World Wide Web site at www.tax.illinois.gov.

The indexes of Income Tax letter rulings for 1990, 1991, 1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005 and 2006 are available for $3.00. A cumulative Income Tax Sunshine Index of 1981 through 1989 letter rulings may be purchased for $4.00.

3. Name and address of person to contact concerning this information:

Linda Settle
Illinois Department of Revenue
Legal Services Office
101 West Jefferson Street
Springfield, Illinois 62794
Telephone: (217) 782-7055

DEPARTMENT OF REVENUE

NOTICE OF PUBLIC INFORMATION

2007 SECOND QUARTER INCOME TAX SUNSHINE INDEX

BASE INCOME

IT 07-0014-GIL 04/03/2007 Response to questionnaire on Illinois tax treatment of sales and exchanges given special federal income tax treatment.

IT 07-0017-GIL 04/13/2007 Illinois tax treatment of IRC Section 338(h)(10) transactions follows the federal treatment.

BINGO, PULL TABS AND CHARITABLE GAMES

IT 07-0019-GIL 04/30/2007 Raffles of real property to benefit the individual owner are not lawful.

CREDITS – FOREIGN TAX

IT 07-0015-GIL 04/05/2007 Computation of income double-taxed by Illinois and California explained.

IT 07-0018-GIL 04/17/2007 Computation of income double-taxed by Illinois and Wisconsin explained.

IT 07-0024-GIL 06/19/2007 Explanation of computation of "double taxed income" for Wisconsin.

DEFICIENCIES

IT 07-0023-GIL 05/24/2007 A notice of deficiency must be sent to the taxpayer's last known address.

ESTIMATED TAX

IT 07-0020-GIL 05/03/2007 No estimated tax payments need be made for a short taxable year, including the short taxable year caused by death of the taxpayer, until regulations are adopted to provide guidance.

DEPARTMENT OF REVENUE

NOTICE OF PUBLIC INFORMATION

2007 SECOND QUARTER INCOME TAX SUNSHINE INDEX

MISCELLANEOUS

IT 07-0021-GIL 05/17/2007 Response to Multistate Tax Commission survey on adoption by Illinois of model regulations and statutes.

REFUNDS

IT 07-0016-GIL 4/09/2007 Overpayments resulting from failure to subtract premium amortization on municipal bonds may be recovered by filing timely refund claims.

WITHHOLDING

IT 07-0013-GIL 04/02/2007 Withholding of Illinois income tax is required when federal income tax is withheld from compensation paid in this State.

WITHHOLDING – OTHER RULINGS

IT 07-0022-GIL 05/24/2007 Withholding from compensation of a nonresident is required only if the compensation is "paid in this State" under IITA Section 304(a)(2)(B).

PROCLAMATIONS

2007-240
GHANAFEST DAY

WHEREAS, on July 28th, the Ghana National Council of Metropolitan Chicago is sponsoring Ghanafest, an annual event that began 19 years ago; and

WHEREAS, Ghanafest attracts thousands of visitors from all over the world. Last year, the festival attracted over twenty thousand participants; and

WHEREAS, Ghanafest is the single largest gathering of African immigrants in the United States; and

WHEREAS, from traditional African arts and crafts and tribal dress to extraordinary Ghanaian foods and musical performances, Ghanafest is a great opportunity to experience the rich and diverse culture of Ghana; and

WHEREAS, this year's theme, "Ghana@50: Continuing the Heritage", pays tribute to the 50th anniversary of Independence in Ghana, an historic event that Ghanaians everywhere are celebrating throughout the year; and

WHEREAS, one of the many indigenous Ghanaians in attendance at the festival this year is the Honorable Dr. Paa Kwesi Ndoum, a member of Ghana's parliament and Minister of Public Sector Reform:

THEREFORE, I, Rod R. Blagojevich, Governor of the State of Illinois, do hereby proclaim July 28, 2007 as **GHANAFEST DAY** in Illinois in tribute to Dr. Ndoum and to all those attending Ghanafest to celebrate Ghana culture and heritage.

Issued by Governor Rod R. Blagojevich
Filed with the Secretary of State on July 17, 2007.

2007-241
GRADUATE EDUCATION WEEK

WHEREAS, graduate schools play an important role in enhancing the nation's economic competitiveness and innovation; and

WHEREAS, the National Science Foundation cites Illinois universities for attracting several billion dollars in federally sponsored grants and contracts over the past five years, most of which is done in conjunction with graduate education; and

WHEREAS, Illinois graduate schools play a vital role in developing the best and brightest domestic and globally recruited talent, evidenced by the fact that about 45 percent of the Illinois legislature have received an advanced degree from an Illinois university, and about 50 percent of certified elementary and secondary school teachers in Illinois have earned graduate degrees; and

WHEREAS, national laboratories in Illinois are dependent on graduate students and faculty from Illinois graduate schools; and

WHEREAS, graduate education is inextricably linked to the global economy, evidenced by Illinois' #1 ranking in the Midwest as a destination for foreign investment, Illinois' ability to attract about 5,000 foreign businesses that employ about 235,000 Illinois citizens, and Illinois graduate schools' ability to attract about 16,000 international students; and

WHEREAS, graduate education accounts for broader societal benefits through more informed civic participation, healthier citizens who live longer lives, more productive workers, innovations in science and technology, and improved performance across a host of socioeconomic measures; and

WHEREAS, the Illinois Association of Graduate Schools, which represents private and public institutions statewide: provides a forum for communication and develop a spirit of cooperation among graduate schools, graduate colleges, and graduate divisions of the colleges and universities of the State of Illinois; plans and implements various mechanisms, consortia, and resource sharing to the benefit and best interests of graduate education and the people of the State of Illinois; serves in an advisory capacity, if so requested, to any State of Illinois agency or commission on matters relating to graduate education; and aims to improve graduate education in the State of Illinois:

THEREFORE, I, Rod R. Blagojevich, Governor of the State of Illinois, do hereby proclaim October 22-26, 2007 as **GRADUATE EDUCATION WEEK** in Illinois and urge all citizens to recognize graduate deans and the Illinois Association of Graduate Schools for all that they do to promote graduate education and contribute to the public good.

Issued by Governor Rod R. Blagojevich
Filed with the Secretary of State on July 18, 2007

2007-242
CHICAGO DEFENDER CHARITIES BUD BILLIKEN DAY

PROCLAMATIONS

WHEREAS, Chicago Defender Charities has a long tradition of helping Illinoisans in need through charitable aid, such as financial assistance and scholarships to students and gift baskets to public housing residents during the holiday season; and

WHEREAS, Chicago Defender Charities also sponsors the annual Bud Billiken Parade, which, for 77 years, has provided free, wholesome, and fun entertainment for hundreds of thousands of children and parents; and

WHEREAS, this year, the Bud Billiken Parade celebrates its 78th anniversary, and the theme, "Education: Our Youth Keys to the Future", emphasizes the importance of educating our children; and

WHEREAS, organizations and events such as Chicago Defender Charities and the Bud Billiken Parade promote community service and unity, which is vital to the strength and success of Illinois communities:

THEREFORE, I, Rod R. Blagojevich, Governor of the State of Illinois, do hereby proclaim August 11, 2007 as CHICAGO DEFENDER CHARITIES BUD BILLIKEN DAY in Illinois in recognition of Chicago Defender Charities' goodwill and to encourage all citizens of the State to support their noble efforts.

Issued by Governor Rod R. Blagojevich
Filed with the Secretary of State on July 19, 2007

ILLINOIS ADMINISTRATIVE CODE
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