HB4039

LRB104 13076 BDA 25057 b

104TH GENERAL ASSEMBLY

State of Illinois

2025 and 2026

HB4039

Introduced 4/8/2025, by Rep. Lindsey LaPointe

SYNOPSIS AS INTRODUCED:

New Act
20 ILCS 2105/2105-372 new
55 ILCS 3-6043 new
730 ILCS 5/3-14-1 from Ch. 38, par. 1003-14-1
730 ILCS 125/19.7 new
730 ILCS 125/19.9 new
210 ILCS 85/17 new
410 ILCS 710/20 new

Creates the Holistic Overdose Prevention and Equity Act. Creates the Harm Reduction Program Board, with certain requirements. Provides that the Department of Public Health shall issue grants to harm reduction providers, with certain requirements. Establishes a Chief Harm Reduction Officer within the Department. Provides for a place-based approach to harm reduction pilot program. Provides for local government training and continuing education. Provides that naloxone shall be made readily available to all staff and individuals in prisons and jails, with certain requirements. Provides for medication for opioid use disorder and fentanyl testing. Restricts the use of abstinence-only or sobriety requirements to housing, with certain requirements. Limits home rule powers. Makes findings. Defines terms. Amends the Department of Professional Regulation Law of the Civil Administrative Code of Illinois, the Counties Code, the County Jail Act, the Unified Code of Corrections, the Hospital Licensing Act, and the Overdose Prevention and Harm Reduction Act to make conforming changes.

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A BILL FOR

AN ACT concerning health.

Be it enacted by the People of the State of Illinois, represented in the General Assembly:

Article 1. General Provisions

Section 1-1. Short title; references to Act.

(a) Short title. This Act may be cited as the Holistic Overdose Prevention and Equity Act.

(b) References to Act. This Act may be referred to as the HOPE Act.

Section 1-5. Findings. The General Assembly finds that:

(1) The Department of Public Health reported 3,261 opioid-related overdose fatalities in 2022, representing an estimated 272 lives lost every month as the State's overdose crisis persists.

(2) The Cook County Medical Examiner's Office confirmed that 2,000 opioid-related deaths occurred in Cook County during 2022, with Black residents comprising 56% of deaths despite only representing 23% of the county's population.

(3) The Opioid Data Dashboard provided by the Department of Public Health vividly demonstrates the extensive reach of opioid-related overdose across the

State; outside of Cook County, the counties that experience the brunt of fatalities include Will County, Winnebago County, DuPage County, Lake County, Kane County, Madison County, St. Clair County, Sangamon County, McHenry County, and Champaign County.

(4) Harm reduction measures have been proven to reduce HIV transmissions, among other benefits, including assisting in the prevention against the acquisition of other bloodborne viruses such as Hepatitis B and C, the prevention of fatal overdoses, decrease in encounters with the criminal justice system, reduction in crime, reduction of social exclusion for people who use drugs, and improvement in access to medical care, mental health support, housing, community support, food, and other basic needs.

(5) Extensive research and reports continue to demonstrate that harm reduction strategies not only save lives by preventing overdose deaths but also limit expenses in response to hospitalizations, emergency calls, and deaths, promote public safety by diverting hazardous waste from public spaces, and do not lead to an increase in crime rates or substance use.

(6) Harm reduction operates on the understanding that recovery is a multifaceted journey and that harm reduction strategies complement traditional recovery approaches.

(7) While people who use drugs continue to face social

stigma, they still possess the right to receive access to housing, education, economic mobility, mental health care, and a range of services to support a better quality of life.

(8) Harm reduction acknowledges the intersecting systems of oppression that marginalize people who use drugs and centers the need for racial, economic, and gender justice within policies and practices.

(9) Across the State, harm reductionists tirelessly dedicate themselves toward mitigating the harms of substance use and providing critical support to individuals in need, and it is essential to recognize and appreciate the strain and labor undertaken by these individuals as they endure secondary trauma and navigate complex social, economic, and political landscapes.

(10) Recent reports have highlighted funding and other stresses endured by harm reduction providers, including inadequate and inefficient distribution of opioid settlement funds.

Section 1-10. Definitions. In this Act:

"Department" means the Department of Public Health.

"Harm reduction" means a philosophical framework and set of strategies designed to reduce harm and promote dignity and well-being among persons and communities who engage in substance use.

"Harm reduction provider" means a needle and hypodermic syringe access program registered with the Department of Public Health, as described in the Overdose Prevention and Harm Reduction Act, where traditional harm reduction services are the agency's primary focus and harm reduction principles guide the organization.

"Harm reduction professional" means a specialist who engages directly with people who use drugs to prevent overdose and infectious disease transmission; improve physical, mental, and social well-being; and offer low barrier options for accessing health care services, including substance use and mental health disorder treatment.

"Overdose prevention site" means a hygienic location where individuals may safely consume pre-obtained substances under observation.

"People with lived or living experience" means individuals who currently or in the past have used drugs, been diagnosed with a substance use disorder, experienced an overdose, or used harm reduction services.

"Medication-assisted treatment" means the use of U.S. Food and Drug Administration-approved medications, in combination with counseling and behavioral therapies, to provide a whole patient approach to the treatment of substance use disorders.

"Medications for opioid use disorder" means the use of U.S. Food and Drug Administration-approved medications to treat opioid use disorders.

Article 2. Harm Reduction Program Board

Section 2-5. Purpose. The Harm Reduction Program Board is created to advance the State's efforts to save lives through harm reduction through improved alignment of existing efforts, sustained and strategic investment, and emphasis on input from people with lived or living experience.

Section 2-10. Membership.

(a) Members of the Harm Reduction Program Board shall represent the diversity of this State and possess the expertise needed to perform the responsibilities of the Harm Reduction Program Board. Members of the Harm Reduction Program Board shall include the following:

(1) One representative of a statewide coalition addressing harm reduction, appointed by the Governor.

(2) One member of the General Assembly, appointed by the President of the Senate.

(3) One member of the General Assembly, appointed by the Speaker of the House of Representatives.

(4) One member of the General Assembly, appointed by the Minority Leader of the Senate.

(5) One member of the General Assembly, appointed by the Minority Leader of the House of Representatives.

(6) The Director of Public Health or the Director's

designee, who shall serve as co-chair.

(7) The Secretary of Human Services or the Secretary's designee.

(8) The Chief Behavioral Health Officer or the Chief Behavioral Health Officer's designee.

(9) The Statewide Opioid Settlement Administrator or the Statewide Opioid Settlement Administrator's designee.

(10) One person with lived or living experience with drug use, substance use disorder, overdose, or use of harm reduction services, appointed by the President of the Senate.

(11) One person with lived or living experience with drug use, substance use disorder, overdose, or use of harm reduction services, appointed by the Speaker of the House of Representatives, who shall serve as co-chair.

(12) One person with lived or living experience with drug use, substance use disorder, overdose, or use of harm reduction services, appointed by the Minority Leader of the Senate.

(13) One person with lived or living experience with drug use, substance use disorder, overdose, or use of harm reduction services, appointed by the Minority Leader of the House of Representatives.

(14) One person who has lost an immediate family member to a fatal overdose, appointed by the Governor.

(15) One representative of a statewide organization of

behavioral health providers, appointed by the Governor.

(16) One representative of a statewide organization of addiction medicine specialists, appointed by the Governor.

(17) Two employees of community-based providers of harm reduction services, appointed by the Director of Public Health.

(18) One person employed by a research institution who has conducted research on harm reduction, appointed by the Director of Public Health.

(19) Additional members with lived or living experience with drug use, substance use disorder, overdose, or use of harm reduction services as needed to ensure that a majority of Harm Reduction Program Board members have lived or living experience, appointed by the Director of Public Health.

(b) Members of the Harm Reduction Program Board shall serve without compensation except those designated as individuals with lived or living experience may receive stipends as compensation for their time. Members of the Harm Reduction Program Board may be reimbursed for reasonable expenses incurred in the performance of their duties from funds appropriated for that purpose.

(c) The Harm Reduction Program Board may exercise any power, perform any function, take any action, or do anything in furtherance of its purposes and goals upon the appointment of a quorum of its members. The Harm Reduction Program Board

terms shall end 4 years from the date of appointment.

Section 2-15. Meetings. The Harm Reduction Program Board shall meet at least quarterly and may do so either in person or remotely. The Department of Public Health shall provide administrative support.

Section 2-20. Responsibilities. Within 12 months after the effective date of this Act, the Harm Reduction Program Board shall:

(1) develop a process to solicit applications for community-based harm reduction grants;

(2) review community-based harm reduction grant applications and proposed agreements and approve the distribution of resources;

(3) develop a process to support ongoing monitoring and evaluation of community-based harm reduction programs; and

(4) deliver an annual report on grants awarded and recommendations for harm reduction public policy to the General Assembly and to the Governor to be posted on the Department of Public Health website.

Article 3. Grant Funding

Section 3-5. Grant-making authority.

(a) The Department of Public Health shall have grant-making, operational, and procurement authority to distribute funds to harm reduction providers to execute the functions established in this Act.

(b) Subject to appropriation, the Department shall issue grants to harm reduction providers. Grants shall be issued on or before September 1 of the relevant fiscal year and shall allow for pre-award expenditures beginning July 1 of the relevant fiscal year.

(c) Beginning in fiscal year 2028 and subject to appropriation, grants shall be awarded for a project period of 3 years, contingent on Department requirements for reporting and successful performance.

(d) The Department shall ensure that grants awarded under this Act do not duplicate or supplant grants awarded under any other Act.

(e) The Department may, subject to appropriation and approval through the Opioid Overdose Prevention and Recovery Steering Committee, after recommendation by the Illinois Opioid Remediation Advisory Board, and certification by the Office of the Attorney General, make harm reduction grants to harm reduction providers addressing opioid remediation in the State for approved abatement uses under the Illinois Opioid Allocation Agreement. The Illinois Opioid Remediation State Trust Fund shall be the source of funding for the program. Eligible grant recipients shall be harm reduction providers

that offer services in a manner that supports and meets the approved uses of the opioid settlement funds. Eligible grant recipients have no entitlement to a grant under this Section. The Department of Public Health may consult with the Department of Human Services to adopt rules to implement this Section and may create a competitive application procedure for grants to be awarded. The rules may specify the manner of applying for grants; grantee eligibility requirements; project eligibility requirements; restrictions on the use of grant moneys; the manner in which grantees must account for the use of grant moneys; and any other provision that the Department of Public Health determines to be necessary or useful for the administration of this Section.

Section 3-10. Grants for harm reduction services.

(a) Subject to appropriation, the Department shall make grants to harm reduction providers.

(b) The Department shall issue grants to ensure that harm reduction services are available in all counties. A harm reduction provider may receive a grant to provide harm reduction services in more than one county.

(c) Harm reduction providers receiving grants under this Act shall establish eligibility criteria for services.

(d) An eligible participant shall not be court ordered to receive services funded by a grant under this Act.

(e) Harm reduction providers receiving grants under this

Act shall provide the following harm reduction services directly or through subgrants to other organizations:

(1) Provision of harm reduction supplies, including, but not limited to, overdose reversal supplies, including naloxone kits with 3 milligram and generic nasal variations; substance test kits, including fentanyl test strips and xylazine test strips; safer sex kits, including condoms; sharps disposal and medication disposal kits; wound care supplies; medication lock boxes; sterile water and saline; ascorbic acid (vitamin C); nicotine cessation therapies; food and beverages (including, snacks, protein drinks, and water); supplies to promote sterile injection and reduce infectious disease transmission through injection drug use; safer smoking kits to reduce infectious disease transmission; FDA-approved home testing kits for viral hepatitis (such as, HBV and HCV) and HIV; written educational materials on safer injection practices and HIV and viral hepatitis and prevention, testing, treatment, and care services; distribution mechanisms (for example, bags for naloxone or safer sex kits, and metal boxes or containers for holding naloxone) for harm reduction supplies, including stock as otherwise described and delineated on this list.

(2) Overdose reversal education and training services.

(3) Navigation services to ensure linkage to HIV and viral hepatitis prevention, testing, treatment, and care

services, including antiretroviral therapy for HCV and HIV, pre-exposure prophylaxis (PEP), post-exposure prophylaxis (PEP), prevention of mother to child transmission, and partner services.

(4) Referral to hepatitis A and hepatitis B vaccinations.

(5) Provision of education on HIV and viral hepatitis prevention, testing, and referral to treatment services.

(6) Provision of information on local resources or referrals for PEP, or both.

(f) Harm reduction providers receiving grants under this Act may provide the following services directly or through subgrants to other organizations:

(1) Contingency management services, in which tangible incentives are given to participants contingent on evidence of change in a specific, incentivized behavior such as abstinence from a particular drug.

(2) Services to promote hygiene and other basic needs, including, but not limited to, mobile showers and clothing distribution.

(3) Other services necessary to promote harm reduction, as determined by the harm reduction provider and approved by the Department.

(g) Harm reduction providers receiving grants under this Act may utilize funds for the following activities, subject to approval by the Department:

(1) compensation and fringe benefits for harm reduction staff and supervisors;

(2) research and evaluation;

(3) community outreach and education; and

(4) building capacity in the harm reduction field.

(h) Grant funds may be used for capital expenses, subject to approval by the Department.

(i) Harm reduction providers receiving grants under this Act shall ensure that services are accessible to individuals with disabilities and to individuals with limited English proficiency. Harm reduction providers receiving grants under this Act shall not deny services to individuals on the basis of immigration status or gender identity.

(j) Unless otherwise provided by law, a harm reduction provider receiving a grant under this Act shall not be compelled to produce any documentation related to confidential disclosures made by an eligible participant to that harm reduction provider, and shall not be compelled to testify regarding confidential disclosures made by such eligible participant, in any criminal proceeding, if the sole purpose for such documentation or testimony is related to an eligible participant's drug use or other related activity.

(k) The Department shall encourage harm reduction providers receiving grants under this Act to employ individuals with lived experience.

Article 4. Administrative Oversight

Section 4-5. Chief Harm Reduction Officer. This Article establishes a Chief Harm Reduction Officer. The Officer shall lead the State's comprehensive, interagency effort to ensure that harm reduction services are available statewide, that the State-supported system respects the dignity of people who use drugs, and that investments in harm reduction services are sustained and strategic. The Officer shall serve as a policymaker and spokesperson on harm reduction, including coordinating the interagency effort through legislation, rules, and budgets; ensuring inclusion of people with lived and living experience in policymaking; communicating with the General Assembly and federal and local leaders on these critical issues; and coordinating with harm reduction providers and other community-based organizations. The Chief Harm Reduction Officer shall be under the jurisdiction of the Department.

Section 4-10. Department of Public Health administering harm reduction programming and funding. Unless otherwise indicated in this Act or in other Acts, harm reduction programming and funding shall be administered by the Department.

Article 5. Training, Technical Assistance, and Education

Section 5-5. Role of harm reduction providers. Organizations or agencies that do not meet the definition of harm reduction provider must subcontract with a harm reduction provider to meet any requirements for harm reduction programming, training, education, or technical assistance established under this Act.

Section 5-10. Local government training. Subject to availability of funding, the Department and the Harm Reduction Program Board shall establish a program to provide comprehensive education and training for local government agencies, including law enforcement and court stakeholders, about this Act and the Overdose Prevention and Harm Reduction Act, with a focus on ensuring compliance with laws that provide immunity for participants, harm reduction providers, and harm reduction staff and volunteers.

Section 5-15. The Department of Professional Regulation Law of the Civil Administrative Code of Illinois is amended by adding Section 2105-372 as follows:

(20 ILCS 2105/2105-372 new)

Sec. 2105-372. Continuing education; harm reduction.

(a) As used in this Section:

"Harm reduction" means a philosophical framework and set

of strategies designed to reduce harm and promote dignity and well-being among persons and communities who engage in substance use.

"Health care professional" means a person licensed or registered by the Department under the following Acts: the Medical Practice Act of 1987, the Nurse Practice Act, the Clinical Psychologist Licensing Act, the Illinois Optometric Practice Act of 1987, the Illinois Physical Therapy Act, the Pharmacy Practice Act, the Physician Assistant Practice Act of 1987, the Clinical Social Work and Social Work Practice Act, the Nursing Home Administrators Licensing and Disciplinary Act, the Illinois Occupational Therapy Practice Act, the Podiatric Medical Practice Act of 1987, the Respiratory Care Practice Act, the Professional Counselor and Clinical Professional Counselor Licensing and Practice Act, the Illinois Speech-Language Pathology and Audiology Practice Act, the Illinois Dental Practice Act, or the Behavior Analyst Licensing Act.

(b) For health care professional license or registration renewals occurring on or after January 1, 2027, a health care professional who has continuing education requirements must complete at least a one-hour course or training on harm reduction. A health care professional may count this one hour for completion of this course toward meeting the minimum credit hours required for continuing education.

(c) Any course or training offered to meet the

requirements of this Section must be designed by or delivered by a harm reduction provider or harm reduction professional.

(d) The Department may adopt rules for the implementation of this Section.

Article 6. Place-Based Approach to Harm Reduction

Section 6-5. Intent; purpose. This Article creates a place-based approach to expand harm reduction education and training, community engagement, mobile outreach, and medication-assisted treatment in the communities with the highest levels of overdoses and greatest unmet need for harm reduction services.

Section 6-10. Pilot.

(a) Subject to availability of funding, the Department shall make grants to one harm reduction provider in a community in each Department region to coordinate a place-based approach to harm reduction.

(b) Harm reduction providers receiving grants under this Article shall provide the following services directly, through subgrants to other organizations, or in coordination with organizations receiving funding from other sources:

(1) Community education and engagement on harm reduction.

(2) Mobile outreach to the populations at highest risk

of overdose.

(3) Provision of or referral to medication-assisted treatment.

(c) Harm reduction providers receiving grants under this Article may provide other services as necessary to expand harm reduction and prevent overdose in the community, either directly, through subgrants to other organizations, or in coordination with organizations receiving funding from other sources, as determined by the harm reduction provider and approved by the Department.

(d) The harm reduction provider shall provide training and technical assistance on harm reduction to subgrantees and other collaborating organizations.

(e) Harm reduction providers receiving grants under this Article and collaborating organizations are prohibited from sharing information about participants with law enforcement and from undertaking activities to increase arrest or prosecution for drug-related offenses or of people who use drugs.

Section 6-15. Community selection. The Department shall determine communities for the pilot by considering the following factors:

(1) community population and poverty level;

(2) the geographic size of a community;

(3) the number of fatal and nonfatal overdoses in the

community;

(4) recent trends in the number of overdoses in the community;

(5) the number of harm reduction providers in the community; and

(6) how many people are served by harm reduction providers in the community.

Article 7. Correctional Facilities

Section 7-5. Incarceration; naloxone. Naloxone shall be made readily available to all correctional staff, health care staff, other staff, and incarcerated individuals in all prisons and jails, subject to the availability of funding to support the prison or jail in obtaining a supply of naloxone.

Section 7-10. The Counties Code is amended by adding Section 3-6043 as follows:

(55 ILCS 5/3-6043 new)

Sec. 3-6043. Release; naloxone. Upon the release of a prisoner from a correctional institution, the sheriff shall provide the prisoner with naloxone and a referral to a harm reduction provider.

Section 7-15. The Unified Code of Corrections is amended

by changing Section 3-14-1 as follows:

(730 ILCS 5/3-14-1) (from Ch. 38, par. 1003-14-1)

Sec. 3-14-1. Release from the institution.

(a) Upon release of a person on parole, mandatory release, final discharge, or pardon, the Department shall return all property held for him, provide him with suitable clothing and procure necessary transportation for him to his designated place of residence and employment. It may provide such person with a grant of money for travel and expenses which may be paid in installments. The amount of the money grant shall be determined by the Department.

(a-1) The Department shall, before a wrongfully imprisoned person, as defined in Section 3-1-2 of this Code, is discharged from the Department, provide him or her with any documents necessary after discharge.

(a-2) The Department of Corrections may establish and maintain, in any institution it administers, revolving funds to be known as "Travel and Allowances Revolving Funds". These revolving funds shall be used for advancing travel and expense allowances to committed, paroled, and discharged prisoners. The moneys paid into such revolving funds shall be from appropriations to the Department for Committed, Paroled, and Discharged Prisoners.

(a-3) Upon release of a person who is eligible to vote on parole, mandatory release, final discharge, or pardon, the

Department shall provide the person with a form that informs him or her that his or her voting rights have been restored and a voter registration application. The Department shall have available voter registration applications in the languages provided by the Illinois State Board of Elections. The form that informs the person that his or her rights have been restored shall include the following information:

(1) All voting rights are restored upon release from the Department's custody.

(2) A person who is eligible to vote must register in order to be able to vote.

The Department of Corrections shall confirm that the person received the voter registration application and has been informed that his or her voting rights have been restored.

(a-4) Prior to release of a person on parole, mandatory supervised release, final discharge, or pardon, the Department shall screen every person for Medicaid eligibility. Officials of the correctional institution or facility where the committed person is assigned shall assist an eligible person to complete a Medicaid application to ensure that the person begins receiving benefits as soon as possible after his or her release. The application must include the eligible person's address associated with his or her residence upon release from the facility. If the residence is temporary, the eligible person must notify the Department of Human Services of his or

her change in address upon transition to permanent housing.

(b) (Blank).

(c) Except as otherwise provided in this Code, the Department shall establish procedures to provide written notification of any release of any person who has been convicted of a felony to the State's Attorney and sheriff of the county from which the offender was committed, and the State's Attorney and sheriff of the county into which the offender is to be paroled or released. Except as otherwise provided in this Code, the Department shall establish procedures to provide written notification to the proper law enforcement agency for any municipality of any release of any person who has been convicted of a felony if the arrest of the offender or the commission of the offense took place in the municipality, if the offender is to be paroled or released into the municipality, or if the offender resided in the municipality at the time of the commission of the offense. If a person convicted of a felony who is in the custody of the Department of Corrections or on parole or mandatory supervised release informs the Department that he or she has resided, resides, or will reside at an address that is a housing facility owned, managed, operated, or leased by a public housing agency, the Department must send written notification of that information to the public housing agency that owns, manages, operates, or leases the housing facility. The written notification shall, when possible, be given at least 14 days

before release of the person from custody, or as soon thereafter as possible. The written notification shall be provided electronically if the State's Attorney, sheriff, proper law enforcement agency, or public housing agency has provided the Department with an accurate and up to date email address.

(c-1) (Blank).

(c-2) The Department shall establish procedures to provide notice to the Illinois State Police of the release or discharge of persons convicted of violations of the Methamphetamine Control and Community Protection Act or a violation of the Methamphetamine Precursor Control Act. The Illinois State Police shall make this information available to local, State, or federal law enforcement agencies upon request.

(c-5) If a person on parole or mandatory supervised release becomes a resident of a facility licensed or regulated by the Department of Public Health, the Illinois Department of Public Aid, or the Illinois Department of Human Services, the Department of Corrections shall provide copies of the following information to the appropriate licensing or regulating Department and the licensed or regulated facility where the person becomes a resident:

(1) The mittimus and any pre-sentence investigation reports.

(2) The social evaluation prepared pursuant to Section

3-8-2.

(3) Any pre-release evaluation conducted pursuant to subsection (j) of Section 3-6-2.

(4) Reports of disciplinary infractions and dispositions.

(5) Any parole plan, including orders issued by the Prisoner Review Board, and any violation reports and dispositions.

(6) The name and contact information for the assigned parole agent and parole supervisor.

This information shall be provided within 3 days of the person becoming a resident of the facility.

(c-10) If a person on parole or mandatory supervised release becomes a resident of a facility licensed or regulated by the Department of Public Health, the Illinois Department of Public Aid, or the Illinois Department of Human Services, the Department of Corrections shall provide written notification of such residence to the following:

(1) The Prisoner Review Board.

(2) The chief of police and sheriff in the municipality and county in which the licensed facility is located.

The notification shall be provided within 3 days of the person becoming a resident of the facility.

(d) Upon the release of a committed person on parole, mandatory supervised release, final discharge, or pardon, the

Department shall provide such person with information concerning programs and services of the Illinois Department of Public Health to ascertain whether such person has been exposed to the human immunodeficiency virus (HIV) or any identified causative agent of Acquired Immunodeficiency Syndrome (AIDS).

(d-5) Upon the release of a committed person from a correctional institution or facility, the Department shall provide the committed person with naloxone and a referral to a harm reduction provider.

(e) Upon the release of a committed person on parole, mandatory supervised release, final discharge, pardon, or who has been wrongfully imprisoned, the Department shall verify the released person's full name, date of birth, and social security number. If verification is made by the Department by obtaining a certified copy of the released person's birth certificate and the released person's social security card or other documents authorized by the Secretary, the Department shall provide the birth certificate and social security card or other documents authorized by the Secretary to the released person. If verification by the Department is done by means other than obtaining a certified copy of the released person's birth certificate and the released person's social security card or other documents authorized by the Secretary, the Department shall complete a verification form, prescribed by the Secretary of State, and shall provide that verification

form to the released person.

(f) Forty-five days prior to the scheduled discharge of a person committed to the custody of the Department of Corrections, the Department shall give the person:

(1) who is otherwise uninsured an opportunity to apply for health care coverage including medical assistance under Article V of the Illinois Public Aid Code in accordance with subsection (b) of Section 1-8.5 of the Illinois Public Aid Code, and the Department of Corrections shall provide assistance with completion of the application for health care coverage including medical assistance;

(2) information about obtaining a standard Illinois Identification Card or a limited-term Illinois Identification Card under Section 4 of the Illinois Identification Card Act if the person has not been issued an Illinois Identification Card under subsection (a-20) of Section 4 of the Illinois Identification Card Act;

(3) information about voter registration and may distribute information prepared by the State Board of Elections. The Department of Corrections may enter into an interagency contract with the State Board of Elections to participate in the automatic voter registration program and be a designated automatic voter registration agency under Section 1A-16.2 of the Election Code;

(4) information about job listings upon discharge from

the correctional institution or facility;

(5) information about available housing upon discharge from the correctional institution or facility;

(6) a directory of elected State officials and of officials elected in the county and municipality, if any, in which the committed person intends to reside upon discharge from the correctional institution or facility; and

(7) any other information that the Department of Corrections deems necessary to provide the committed person in order for the committed person to reenter the community and avoid recidivism.

(g) Sixty days before the scheduled discharge of a person committed to the custody of the Department or upon receipt of the person's certified birth certificate and social security card as set forth in subsection (d) of Section 3-8-1 of this Act, whichever occurs later, the Department shall transmit an application for an Identification Card to the Secretary of State, in accordance with subsection (a-20) of Section 4 of the Illinois Identification Card Act.

The Department may adopt rules to implement this Section. (Source: P.A. 102-538, eff. 8-20-21; 102-558, eff. 8-20-21; 102-606, eff. 1-1-22; 102-813, eff. 5-13-22; 103-345, eff. 1-1-24.)

Section 7-20. The County Jail Act is amended by adding

Sections 19.7 and 19.9 as follows:

(730 ILCS 125/19.7 new)

Sec. 19.7. Release; naloxone. Upon the release of a prisoner from a jail, the warden shall provide the prisoner with naloxone, subject to the availability of funding to support the jail in obtaining a supply of naloxone, and a referral to a harm reduction provider.

(730 ILCS 125/19.9 new)

Sec. 19.9. Medication for opioid use disorder.

(a) In this Section:

"Clinically indicated" means a medical procedure or treatment is based upon the treatment provider's medical judgment in accordance with the current generally accepted standards of care.

"Medication-assisted treatment" means the use of U.S. Food and Drug Administration-approved medications, in combination with counseling and behavioral therapies, to provide a whole patient approach to the treatment of substance use disorders.

"Medications for opioid use disorder" means the use of U.S. Food and Drug Administration-approved medications to treat substance use disorders.

(b) Within 24 hours of admission to a jail, each detained person shall be screened for substance use disorders as part of an initial and ongoing substance use screening and

assessment process. This process includes screening and assessment for opioid use disorders.

(c) A detained person who is admitted to a jail while under the medical care of a licensed physician, a licensed physician assistant, or a licensed nurse practitioner and who is taking medication at the time of admission in accordance with a valid prescription as verified by the individual's pharmacy of record, primary care provider, other licensed care provider, or a prescription monitoring or information system, shall have that medication continued and provided by the jail pending an evaluation by a licensed physician, a licensed physician assistant, or a licensed nurse practitioner and subject to the treatment provider's medical judgment. The jail may defer provision of a validly prescribed medication in accordance with this subsection if, in the judgment of a licensed physician, a licensed physician assistant, or a licensed nurse practitioner, continuation of the medication is no longer clinically indicated.

A detained person who is admitted to a jail while under the medical care of a licensed physician, a licensed physician assistant, or a licensed nurse practitioner and who is taking medication for an opioid use disorder or participating in medication-assisted treatment at the time of admission in accordance with a valid prescription as verified by the individual's pharmacy of record, primary care provider, other licensed care provider, or a prescription monitoring or

information system, shall have the detained person's medication continued and provided by the jail pending an evaluation by a licensed physician, a licensed physician assistant, or a licensed nurse practitioner and subject to the treatment provider's medical judgment. The jail may defer provision of a validly prescribed medication in accordance with this subsection if, in the judgment of a licensed physician, a licensed physician assistant, or a licensed nurse practitioner, continuation of the medication is no longer clinically indicated. An individual participating in a medication-assisted treatment program may have counseling and behavioral therapies continued to the extent possible.

If at any time a detained person screens positive as having or being at risk for an opioid use disorder, is diagnosed with an opioid use disorder or is exhibiting symptoms of withdrawal from an opioid use disorder, and medication-assisted treatment is clinically indicated by a licensed physician, a licensed physician assistant, or a licensed nurse practitioner, then the individual may consent to commence medications for opioid use disorder, which shall be provided by the jail. The detained person shall be authorized to receive the medication immediately and for as long as clinically indicated.

(d) The licensed practitioner who makes the clinical judgment to discontinue the use of medication shall enter the reason for the discontinuance to be entered into the detained

person's medical record, specifically stating the reason for discontinuance. The individual shall be provided, both orally and in writing, with a specific explanation of the decision to discontinue the medication.

(e) As part of the reentry planning, the jail shall commence medications for opioid use disorder prior to an individual's release if:

(1) the individual screens positive as having an opioid use disorder, being at risk for an opioid use disorder, or exhibiting symptoms of withdrawal from an opioid use disorder;

(2) medication-assisted treatment is clinically indicated by a licensed physician, a licensed physician assistant, or a licensed nurse practitioner; and

(3) the individual consents to commence medications for opioid use disorder.

Upon reentry, the jail shall provide an individual participating in medication-assisted treatment with a referral to a provider in the community who may assist the individual with continued medications for opioid use disorder and medication-assisted treatment care.

Article 8. Health Care Facilities

Section 8-5. Medication for opioid use disorder. All acute care hospitals that provide emergency services in an emergency

department, all satellite emergency facilities, and all inpatient behavioral health treatment providers shall maintain, as part of their services, protocols and capacity to provide appropriate, evidence-based interventions prior to discharge that reduce the risk of subsequent harm and fatality following an opioid-related overdose, including, but not limited to, institutional protocols and capacity to possess, dispense, administer, and prescribe all FDA-approved forms of medication for opioid use disorder. Such treatment shall be offered to all patients who present in an acute care hospital emergency department, a satellite emergency facility, or inpatient behavioral health treatment provider for care and treatment of an opioid-related overdose or opioid use disorder; if that treatment shall only occur when it is recommended by the treating healthcare provider and is voluntarily agreed to by the patient. Acute care hospitals that provide emergency services in an emergency department, satellite emergency facilities, and inpatient behavioral health treatment providers shall demonstrate compliance with applicable training and waiver requirements established by the federal Drug Enforcement Agency and the federal Substance Abuse and Mental Health Services Administration relative to prescribing medication for opioid use disorder. Prior to discharge, any patient who is administered or prescribed medication for opioid use disorder in an acute care hospital emergency department, satellite emergency facility, or

inpatient behavioral health treatment provider shall be directly connected to an appropriate provider or treatment site to voluntarily continue the treatment.

Section 8-10. Patient discharge and education on naloxone; provider referral. Upon discharge of a patient from an acute care hospital, satellite emergency facility, or inpatient behavioral health treatment provider who has: (i) a history of or is actively using opioids or other illicit drugs; (ii) been diagnosed with opioid use disorder; or (iii) experienced an opioid-related overdose, the acute care hospital, satellite emergency facility, or inpatient behavioral health treatment provider shall educate the patient on the use of naloxone, dispense not less than 2 doses of naloxone to the patient or a legal guardian of the patient, and directly connect the patient to a harm reduction provider.

Section 8-15. Rulemaking. The Department may adopt rules for the implementation of this Article.

Section 8-20. The Hospital Licensing Act is amended by adding Section 17 as follows:

(210 ILCS 85/17 new)

Sec. 17. Fentanyl testing.

(a) If an individual is treated at a hospital and the

hospital conducts a urine drug screening to assist in diagnosing the individual's condition, the hospital shall include testing for fentanyl in the individual's urine screening.

(b) If the urine drug screening conducted in accordance with subsection (a) detects fentanyl, the hospital shall report the test results, which shall be deidentified, to the Department through the State-designated health information exchange.

(c) This Section does not apply to a hospital that does not have chemical analyzer equipment.

(d) This Section does not affect any State law providing civil or criminal immunity to an individual who is in need of medical assistance after ingesting or using alcohol or drugs, or to an individual who, in good faith, assists another individual who is in need of medical assistance after ingesting or using alcohol or drugs.

Article 9. Housing

Section 9-5. Low barrier housing. Community-based service providers that are funded or regulated by the State to offer shelter, recovery homes, housing, or housing vouchers shall adopt a low barrier approach that prioritizes provision of stable housing before addressing other social needs and incorporates the following requirements:

(1) Applicants may not be rejected and residents may not be evicted solely based on abstinence-only or sobriety requirements. Behaviors while intoxicated that violate the terms of residency may be grounds for rejection of an applicant for housing or eviction of a resident.

(2) Discrimination against applicants solely on the basis of criminal records, records of arrests, charges, or convictions on drug-related offenses is prohibited.

These requirements do not apply to operators or owners of rental housing on the private market.

Section 9-10. Housing evictions based on opioid use disorder treatment. All operators or owners of housing are prohibited from rejecting applicants or evicting residents because they are receiving medication for opioid use disorder or other forms of medication-assisted treatment.

Section 9-15. Federal requirements. Nothing in this Article shall be construed to prohibit a housing provider from complying with federal laws or regulations if housing is provided using both federal and State funding.

Article 10. Home Rule Preemption

Section 10-5. Home rule preemption.

(a) A home rule unit may not prohibit the establishment or

operation of any harm reduction activities as provided in this Act.

(b) A municipality may not adopt zoning regulations for the sole purpose of prohibiting the establishment or operation of any harm reduction activities as provided in this Act.

(c) This Section is a denial and limitation of home rule powers and functions under subsection (g) of Section 6 of Article VII of the Illinois Constitution.

Section 10-10. The Overdose Prevention and Harm Reduction Act is amended by adding Section 20 as follows:

(410 ILCS 710/20 new)

Sec. 20. Home rule preemption. A home rule unit may not prohibit the establishment or operation of a needle and hypodermic syringe access program as provided in this Act. This Section is a denial and limitation of home rule powers and functions under subsection (g) of Section 6 of Article VII of the Illinois Constitution.