

5123:2-3-03

**Licensed residential facilities - person-centered planning.****(A) Purpose**

This rule ensures that services for individuals living in residential facilities licensed in accordance with section 5123.19 of the Revised Code are delivered pursuant to an individual plan or individual service plan that is developed through person-centered planning.

**(B) Definitions**

- (1) "Home and community-based services" has the same meaning as in section 5123.01 of the Revised Code.
- (2) "Individual" means a person with a developmental disability.
- (3) "Individual plan" or "individual service plan" means the written description of services, supports, and activities to be provided to an individual.
- (4) "Informed consent" means a documented written agreement to allow a proposed action, treatment, or service after full disclosure provided in a manner the individual or his or her guardian understands, of the relevant facts necessary to make the decision. Relevant facts include the risks and benefits of the action, treatment, or service; the risks and benefits of the alternatives to the action, treatment, or service; and the right to refuse the action, treatment, or service. The individual or his or her guardian, as applicable, may revoke informed consent at any time.
- (5) "Intermediate care facility for individuals with intellectual disabilities" has the same meaning as in section 5124.01 of the Revised Code.
- (6) "Person-centered planning" means an ongoing process directed by an individual and others chosen by the individual to identify the individual's unique strengths, interests, abilities, preferences, resources, and desired outcomes as they relate to the individual's support needs.
- (7) "Qualified intellectual disability professional" has the same meaning as in 42 C.F.R. 483.430 as in effect on the effective date of this rule.
- (8) "Residential facility" has the same meaning as in section 5123.19 of the Revised Code.
- (9) "Service and support administrator" means a person, regardless of title, employed by or under contract with a county board of developmental disabilities to perform the functions of service and support administration and who holds the appropriate certification in accordance with rule 5123:2-5-02 of the Administrative Code.

(10) "Team," as applicable, has the same meaning as in rule 5123:2-1-11 of the Administrative Code or means an interdisciplinary team as that term is used in 42 C.F.R. 483.440 as in effect on the effective date of this rule.

(C) Decision-making responsibility

(1) Individuals, including individuals who have been adjudicated incompetent pursuant to Chapter 2111. of the Revised Code, have the right to participate in decisions that affect their lives and to have their needs, desires, and preferences considered.

(2) An individual for whom a guardian has not been appointed shall make decisions regarding receipt of a service or support or participation in a program provided for or funded under Chapter 5123. or 5126. of the Revised Code. The individual may obtain support and guidance from another person; doing so does not affect the right of the individual to make decisions.

(3) An individual for whom a guardian has not been appointed may, in accordance with section 5126.043 of the Revised Code, authorize an adult (which may be referred to as a "chosen representative") to make a decision described in paragraph (C)(2) of this rule on behalf of the individual as long as the adult does not have a financial interest in the decision. The authorization shall be made in writing.

(4) When a guardian has been appointed for an individual, the guardian shall make a decision described in paragraph (C)(2) of this rule on behalf of the individual within the scope of the guardian's authority. This paragraph shall not be construed to require appointment of a guardian.

(5) An adult or guardian who makes a decision pursuant to paragraph (C)(3) or (C)(4) of this rule shall make a decision that is in the best interest of the individual on whose behalf the decision is made and that is consistent with the individual's needs, desires, and preferences.

(D) Development of individual plans and individual service plans

(1) Person-centered planning shall be the foundation for development of individual plans and individual service plans.

(2) Individual service plans for individuals who reside in residential facilities other than intermediate care facilities for individuals with intellectual disabilities shall be developed with the individual by a service and support administrator in accordance with rule 5123:2-1-11 of the Administrative Code.

(3) Individual plans for individuals who reside in intermediate care facilities for individuals with intellectual disabilities shall be developed in accordance with

paragraph (E) of this rule.

(E) Requirements for development of individual plans for individuals who reside in intermediate care facilities for individuals with intellectual disabilities

(1) What is important to the individual and what is important for the individual as expressed directly by the individual, and as applicable, by an adult authorized by the individual or the individual's guardian shall drive development of the individual plan.

(2) The services, supports, and activities described in the individual plan shall reflect what is important to the individual and what is important for the individual, meet the individual's needs, provide opportunities for the individual to interact with persons without disabilities in integrated community settings, and assist the individual in expanding and developing skills that will lead to a more independent, secure, and enjoyable life.

(3) Evaluations shall be used as a resource to identify appropriate methods of developing the services, supports, and activities necessary to meet the needs of the individual.

(a) The following evaluations of the individual shall be conducted as needed and at least annually:

(i) A general health evaluation including vision, hearing, and other screenings appropriate for the individual's age and gender;

(ii) An evaluation of the individual's general dental health and hygiene;  
and

(iii) An adaptive behavior or independent living skills assessment.

(b) The individual's social history shall be reviewed at least annually and updated as needed.

(c) If the results from the evaluations described in paragraphs (E)(3)(a) and (E)(3)(b) of this rule are insufficient to identify appropriate methods of developing the services, supports, and activities necessary to meet the needs of the individual, additional evaluations shall be obtained.

(4) The qualified intellectual disability professional shall:

(a) Coordinate development of the individual plan with the individual and the team within thirty calendar days after the individual's admission and at least annually thereafter.

(b) Describe, annually and upon request, the supports and services available

to an individual residing in an intermediate care facility for individuals with intellectual disabilities and the supports and services available to an individual enrolled in a home and community-based services waiver.

(c) Ensure that development of the initial individual plan and each subsequent individual plan reflects meaningful planning for:

(i) The individual's discharge from the intermediate care facility for individuals with intellectual disabilities that:

(a) Identifies supports and services necessary for the individual's successful transition to an integrated community setting and specifies who is responsible for ensuring necessary supports and services are provided; and

(b) Includes strategies or methods for eliminating or overcoming barriers preventing the individual from transitioning to an integrated community setting.

(ii) The individual's unique strengths, interests, abilities, preferences, resources, and desired outcomes as they relate to community employment in accordance with rule 5123:2-2-05 of the Administrative Code.

(d) Review the individual plan as needed or upon request.

(e) Review implementation of the individual plan at least quarterly and revise as needed.

(f) Coordinate the services, supports, and activities being provided to the individual with service providers, as identified in the individual plan.

(g) Contact the county board when an individual residing in the intermediate care facility for individuals with intellectual disabilities requests, or a person on the individual's behalf requests pursuant to paragraph (C) of this rule, assistance to move from the intermediate care facility for individuals with intellectual disabilities to a community setting.

(h) Document performance of the tasks described in paragraphs (E)(4)(a) to (E)(4)(g) of this rule.

(5) The qualified intellectual disability professional shall secure informed consent for the individual plan from the individual, adult authorized by the individual, or the individual's guardian, as applicable.

(6) The qualified intellectual disability professional shall attempt to address concerns when informed consent is refused or revoked by presenting

alternative services or activities to the individual.

(7) The individual plan shall be provided to the individual, adult authorized by the individual, or individual's guardian, as applicable; to all parties responsible for implementation of the individual plan; and to authorized regulatory agents. The individual plan shall not be released to other persons without the informed consent of the individual, adult authorized by the individual, or individual's guardian, as applicable.

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Certification

02/29/2016

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Date

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