Person-Centered Planning
Addition of New 14 NYCRR Part 636
Amendments to 14 NYCRR Parts 633, 635, 671, & 686
FINAL REGULATIONS

Effective Date: November 1, 2015

- **A new Part 636 is added to 14 NYCRR as follows:**

Part 636 Services and Supports for Individuals with Developmental Disabilities

Subpart 636-1 Person-Centered Planning

Section 636-1.1 *Applicability*.

(a) This subpart applies to:

(1) OPWDD funded Home and Community Based Services (HCBS) Medicaid Waiver services; and

(2) OPWDD funded service coordination services, by whatever name known (e.g., Medicaid Service Coordination), provided to individuals who receive OPWDD funded HCBS Medicaid Waiver services

(b) This subpart applies to the service planning process for all HCBS Medicaid Waiver services funded by OPWDD.

Section 636-1.2 *Person-Centered Planning Process*.

(a) A person-centered planning process is a process in which, to the maximum extent possible, an individual directs the planning of his or her services and makes informed choices about the services and supports that he or she receives. The planning process guides the delivery of services and supports to an individual in a way that leads to outcomes or results in areas of the individual's life that are most important to him or her (e.g., health, relationships, work, and home).

(1) The person-centered planning process involves parties chosen by the individual, often known as the individual's circle of support. The parties chosen by the individual participate in the process as needed, and as defined by the individual, except to the extent that decision-making authority is conferred on another by state law.

(2) The parties chosen by the individual assist the individual in decision-making by, among other things, explaining issues to be decided, answering the individual's questions, encouraging the individual to actively participate in decision-making and, where necessary, assisting the individual to communicate his or her preferences.

(3) The person-centered planning process requires that:

(i) supports and services are based on the individual's interests, preferences, strengths, capacities, and needs;

(ii) supports and services are designed to empower the individual by fostering skills to achieve desired personal relationships, community participation, dignity, and respect; and

(iii) the individual is satisfied with activities, supports, and services.

(4) Person centered planning is a collaborative and recurring process between the individual and the service provider. The planning process is used at the time of initial plan development and during reviews of the plan.

(b) A person-centered planning process is required for developing the person-centered service plan (see section 636-1.3 of this subpart), including the HCBS Waiver service habilitation plan, with the individual and parties chosen by the individual. The person-centered planning process involves:

(1) providing necessary information and support to ensure that the individual, to the maximum extent possible, directs the process and is enabled to make informed choices and decisions;

(2) scheduling with the individual at times and locations of convenience to the individual;

(3) taking into account the cultural considerations of the individual and providing information in plain language and in a manner that is accessible to and understood by the individual and parties chosen by the individual;

(4) providing a method for the individual to request updates to the person-centered service plan as needed; and

(5) developing strategies that address conflicts or disagreements in the process, including clear conflict of interest guidelines for individuals, and communicating such strategies to the individual who is receiving services as appropriate.

Section 636-1.3 *Person-Centered Service Plan*.

(a) The person-centered service plan is created using the planning process described in section 636-1.2 of this subpart. The person-centered service plan may also be known as the individualized service plan (ISP, see definition in section 635-99.1 of this Title).

(b) The individual's service coordinator must develop a person-centered service plan with the individual. The plan must include and document the following:

(1) the individual's goals and desired outcomes;

(2) the individual's strengths and preferences;

(3) the individual's clinical and support needs as identified through an assessment of functional and health-related needs;

(4) the necessary and appropriate services and supports (paid and unpaid) that are based on the individual's preferences and needs (as identified through an assessment of functional and health-related needs) and that will assist the individual to achieve his or her identified goals;

(5) the services that the individual elects to self-direct;

(6) the providers of those services and supports specified in paragraph (4) and (5) of this subdivision;

(7) if an individual resides in a certified residential setting, document that the residence was chosen by the individual, and document the alternative residential

settings considered by the individual, including alternative residential settings that are available to individuals without disabilities (Note: The setting chosen by the individual is integrated in, and supports full access of individuals receiving services to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community having the same degree of access to the community as individuals not receiving services. The individual may choose service and support options that are available to individuals without disabilities for his or her residence and other areas of his or her life.);

(8) the risk factors and measures in place to minimize risk, including individual specific back-up plans and strategies when needed; and

(9) the individual and/or entity responsible for monitoring the plan.

(c) The service coordinator must develop the person-centered service plan in a way that is understandable to the individual and parties chosen by the individual. At a minimum, for the written plan to be understandable, it must be written in plain language and in a manner that is accessible to the individual, to the extent possible, and parties chosen by the individual.

(d) The plan must be finalized and agreed to with the individual's written informed consent and signed by the provider(s) responsible for implementing the person-centered service plan.

(e) The service coordinator must distribute the person-centered service plan to the individual and parties involved in the implementation of the plan.

(f) The individual, parties chosen by the individual, the service provider, and service coordinator must review the person-centered service plan described in subdivision (b) of this section and subdivisions 636-1.4(c) and (d) of this subpart, and the service coordinator must revise such plan if necessary, as follows:

(1) at least semi-annually;

(2) when the capabilities, capacities, or preferences of the individual have changed and warrant a review;

(3) at the request of the individual and/or parties chosen by the individual;

(4) when it is determined that the existing plan (or portions of the plan) is/are ineffective; and

(5) upon reassessment of the individual's functional need.

Section 636-1.4 *Documentation of Rights Modifications*.

(a) This section only applies to HCBS Medicaid Waiver services in settings certified by OPWDD. (Note: See section 633.16 of this Title for documentation requirements concerning person-centered behavioral intervention and section 633.4 of this Title for documentation requirements concerning modifications of rights of individuals receiving services that are not duplicated in paragraphs (b)(1)-(4) of this section.)

(b) Modifications to the rights identified in paragraphs (1)-(4) of this subdivision of an individual receiving services in a setting described in subdivision (a) of this section must be supported by a specific assessed need and justified in the individual's person-centered service plan:

(1) Each individual's residence is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the applicable landlord/tenant law. For a residence to which landlord tenant laws do not apply, there must be a lease, residency agreement, or other form of written agreement for each individual that provides for eviction processes and appeals comparable to those provided under the applicable landlord tenant law.

(2) Each individual has privacy in his or her sleeping or living unit:

(i) Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors.

(ii) The individual sharing a unit has a choice of roommates in that setting.

(iii) The individual has freedom to furnish and decorate his or her sleeping or living unit within the lease or other agreement.

(3) Each individual has the freedom and support to control his or her own schedules and activities, and has access to food at any time.

(4) Each individual is able to have visitors of his or her choosing at any time.

(c) The service coordinator must ensure documentation of the following in the individual's person-centered service plan:

(1) a specific and individualized assessed need underlying the reason for the modification;

(2) the positive interventions and supports used prior to any modifications;

(3) less intrusive methods of meeting the need that were tried but did not work;

(4) a clear description of the condition that is directly proportionate to the specific assessed need;

(5) a regular collection and review of data to measure the ongoing effectiveness of the modification;

(6) established time limits for periodic reviews to determine if the modification is still necessary or can be terminated;

(7) an assurance that interventions and supports will cause no harm to the individual; and

(8) the informed consent of the individual.

(d) In the event that a rights modification affects another individual receiving services in the setting who does not require a rights modification, the service coordinator must ensure documentation of the following in such individual's person-centered service plan:

(1) the impact that the rights modification has on the individual;

(2) the efforts taken to lessen the impact on the individual; and

(3) the informed consent of the individual.

Section 636-1.5 *Notice of the Person-Centered Planning Process and Plan.*

(a) The service coordinator must give notice of the individual's right to a person-centered planning process in accordance with section 636-1.2 of this subpart and to a person-centered plan in accordance with section 636-1.3 of this subpart, and of the right to object to services pursuant to section 633.12 of this Title, to the individual and the person upon whom decision-making authority is conferred by state law (see paragraph 636-1.2(a)(1) of this subpart), if any, in the following manner:

(1) for individuals who do not have an ISP in place on November 1, 2015, the service coordinator must give written notice prior to the initiation of the person-centered planning process and development of the plan; or

(2) for individuals who have an ISP in place on November 1, 2015, the service coordinator must give written notice at the time of the individual's next ISP review.

(b) Such information must be conveyed in plain language and in a manner that is accessible to and understood by the parties specified in subdivision (a) of this section, where necessary to facilitate comprehension.

- **Paragraph 633.4(a)(3) is amended as follows:**

(3) The rights set forth in this section are intended to establish the living and/or program environment that protects individuals and contributes to providing an environment in keeping with the community at large, to the extent possible, given the degree of the disabilities of those individuals. Rights that are self-initiated or involve privacy or sexuality issues may need to be adapted to meet the need of certain persons with the most severe handicaps and/or persons whose need for protection, safety and health care will justify such adaptation. It is the responsibility of the agency/facility or the sponsoring agency to ensure that rights are not arbitrarily denied. Rights limitations must be documented and must be on an individual basis, for a specific period of time, and for clinical purposes only. (Note: See section 636-1.4 of this Title for documentation requirements specific to the person-centered service plan and section 633.16 of this Part for documentation requirements concerning person-centered behavioral intervention.)

- **Paragraph 633.4(b)(6) is amended as follows:**

(6) For the person who has had limitations placed on any rights, there is documentation in the person's plan of services as the clinical justification and specific period of time the limitation is to remain in effect. (Note: See section 636-1.4 of this Title for documentation requirements specific to the person-centered service plan and section 633.16 of this Part for documentation requirements concerning person-centered behavioral intervention.)

- **New subparagraph 633.10(a)(2)(iv) is added as follows:**

(iv) Where applicable, requirements specified in subpart 636-1 of this Title for a person-centered planning process and person-centered service plan.

- **Paragraph 633.16(c)(9) is amended as follows:**

(9) Additional requirements apply to behavioral interventions which impose a limitation on a person's rights as specified in section 633.4 of this Part, including behavioral consequences negatively impacting the person's dignity (see paragraph [j][2] of this section), and, where applicable, as specified in section 636-1.4 of this Title concerning requirements for documentation of rights modifications in the person-centered service plan.

- **A new subparagraph 633.16(j)(2)(iv) is added as follows:**

(iv) Where applicable, documentation of rights modifications in the person-centered service plan is required in accordance with section 636-1.4 of this Title.

- **Subdivisions 635-99.1(bk) and 686.99(ab) are deleted and replaced with new subdivisions 635-99.1(bk) and 686.99(ab) to read as follows (both subdivisions read the same):**

Plan, individualized service (ISP). The written document that is developed by an individual's chosen service coordinator, the individual and/or the parties chosen by the individual , often known as the person's circle of support, that describes the services, activities and supports, regardless of the funding source, and that constitutes the person's individualized service environment. This document may be known by a different name but it must comprise the elements described in this definition. The goal of the ISP is to ensure the provision of those things necessary to sustain the person in his/her chosen environment and preclude movement to an ICF/DD. These services,

activities and supports, identified in the ISP, are to reflect the preferences, capabilities, and capacities of the person and emphasize the development of self-determination (i.e., making personal choices), independence, productivity, and integration into the community. The ISP identified by personal descriptive and identification information, contains at a minimum:

(1) assessment information and recommendations;

(2) an identification of each service, service provider (including type), the amount, frequency, and duration of each service, and effective dates for service delivery;

(3) an identification of the individual's personal goals, preferences, capabilities, and capacities which are then related to habilitation or support needs stated in terms of outcomes to be achieved within specified timeframes; and

(4) service coordination, including assessment, service planning and coordination, linkage and referral, follow-up and monitoring.

It is the responsibility of the individual's chosen service coordinator to ensure that the ISP is reviewed at least semi-annually and includes consideration of the information obtained from other-than-OPWDD providers (if any), who are providing services (e.g., as appropriate, the individualized plan for employment (IPE) or the individualized education plan (IEP)). The service coordinator should also ensure that a review of the ISP occurs when the individual and/or parties chosen by the individual request it; or when the capabilities, capacities or preferences of the individual have changed and warrant a review; or when it is determined by the service coordinator that the prevailing plan (or portions of the plan) is/are ineffective. If habilitation services are provided (i.e., residential habilitation, day habilitation, community habilitation, supported employment, pre-vocational services, pathway to employment), the relevant habilitation plan(s) must be developed, and on a semiannual basis thereafter, reviewed and revised as necessary by the habilitation service provider. The ISP shall include or contain as attachments the following:

(1) all relevant habilitation plans (for individuals receiving habilitation services);

(2) all relevant plans or documents pursuant to subdivisions 636-1.4(c) and (d) of this Title that support modification to an individual’s rights specified in paragraphs 636-1.4(b)(1)-(4) of this Title; and

(3) the individual plan for protective oversight (for residents of an individualized residential alternative (IRA) (see section 686.16(a)(6) of this Title).

The ISP is equivalent to a clinical record for the purposes of confidentiality and access.

- **Subdivision 671.1(m) is amended as follows:**

(m) Nothing herein shall be interpreted as precluding the applicability of Parts 604, 624, 633, [and] 635 and 636 of this Title to each setting as specified pursuant to each Part. In the event that there is a conflict between the requirements contained herein and any other applicable law or regulation, [the commissioner shall] OPWDD will resolve issues