



Ohio Administrative Code

Rule 5123-3-03 Licensed residential facilities - person-centered planning.

Effective: August 27, 2026

(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 service plan that is developed through person-centered planning.

(B) Definitions

For the purposes of this rule, the following definitions apply:

- (1) "Business day" means a day of the week, excluding Saturday, Sunday, or a legal holiday as defined in section 1.14 of the Revised Code.
- (2) "County board" means a county board of developmental disabilities.
- (3) "Department" means the Ohio department of developmental disabilities.
- (4) "Home and community-based services waiver" means a medicaid waiver administered by the department in accordance with section 5166.21 of the Revised Code.
- (5) "Individual" means a person with a developmental disability.
- (6) "Individual service plan" means the written description of services, supports, and activities to be provided to an individual and includes an "individual program plan" as that term is used in 42 C.F.R. 483.440.
- (7) "Informed consent" means a documented written agreement to allow a proposed action, treatment, or service after full disclosure provided in a manner an individual or the individual's 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 the individual's guardian, as applicable, may withdraw informed consent at any time.
- (8) "Intermediate care facility for individuals with intellectual disabilities" has the same meaning as in section 5124.01 of the Revised Code.
- (9) "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.



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- (10) "Person-centered planning templates" means the department-required formats (i.e., the assessment template and the individual service plan template) that an intermediate care facility for individuals with intellectual disabilities will use to conduct assessments and develop individual service plans for its residents.
- (11) "Qualified intellectual disability professional" has the same meaning as in 42 C.F.R. 483.430.
- (12) "Residential facility" has the same meaning as in section 5123.19 of the Revised Code.
- (13) "Service and support administrator" means a person, regardless of title, employed by or under contract with a county board to perform the functions of service and support administration and who holds the appropriate certification in accordance with rule 5123-5-02 of the Administrative Code.
- (14) "Team," as applicable, has the same meaning as in rule 5123-4-02 of the Administrative Code or means an "interdisciplinary team" as that term is used in 42 C.F.R. 483.440.

(C) Decision-making responsibility

- (1) Each individual, including an individual who has been adjudicated incompetent pursuant to Chapter 2111. of the Revised Code, has the right to participate in decisions that affect the individual's life and to have what is important to the individual and what is important for the individual supported.
- (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 or funded under Chapter 5123., 5124., 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 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 will 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 will not be construed to compel appointment of a guardian.



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- (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 what is important to the individual, what is important for the individual, and the individual's desired outcomes.

(D) Assessment of an individual

- (1) Assessment of an individual who resides in a residential facility other than an intermediate care facility for individuals with intellectual disabilities will be coordinated by a service and support administrator in accordance with rule 5123-4-02 of the Administrative Code.
- (2) Assessment of an individual who resides in an intermediate care facility for individuals with intellectual disabilities will be coordinated by a qualified intellectual disability professional in accordance with this paragraph.
 - (a) With the active participation of the individual and members of the team, including the individual's guardian when applicable, the qualified intellectual disability professional will use the department's person-centered planning template to conduct an assessment of the individual.
 - (b) The assessment will take into consideration:
 - (i) What is important to the individual to promote satisfaction and achievement of desired outcomes;
 - (ii) What is important for the individual to maintain health and welfare;
 - (iii) Known and likely risks;
 - (iv) The individual's place on the path to community employment described in rule 5123-2-05 of the Administrative Code; and
 - (v) The individual's skills and abilities.
 - (c) The assessment will identify the individual's needs in the following domains:
 - (i) Communication (expressing oneself and understanding others);
 - (ii) Advocacy and engagement (valued roles and making choices; responsibility and leadership);



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- (iii) Safety and security (safety and emergency skills; behavioral well-being; emotional well-being; supervision considerations);
- (iv) Social and spirituality (personal networks, activities, and faith; friends and relationships);
- (v) Daily life and employment (school and education; employment; finance);
- (vi) Community living (life at home; getting around); and
- (vii) Healthy living (medical and dental care; nutrition; wellness).

(E) Development of individual service plans

- (1) The individual service plan for an individual who resides in a residential facility other than an intermediate care facility for individuals with intellectual disabilities will be developed by a service and support administrator in accordance with rule 5123-4-02 of the Administrative Code.
- (2) The individual service plan for an individual who resides in an intermediate care facility for individuals with intellectual disabilities will be developed by a qualified intellectual disability professional in accordance with this paragraph.
 - (a) Person-centered planning is the foundation for development of individual service plans. 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 will drive development of the individual service plan.
 - (b) The services, supports, and activities described in the individual service plan will reflect what is important to the individual and what is important for the individual to achieve a more independent, secure, and enjoyable life.
 - (i) The qualified intellectual disability professional shall:
 - (a) Coordinate development of the individual service 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



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supports and services available to an individual enrolled in a home and community-based services waiver.

(c) Ensure that development of the initial individual service plan and each subsequent individual service 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 meeting the challenges for a successful transition 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 5123-2-05 of the Administrative Code.

(d) With the active participation of the individual and members of the team, including the individual's guardian when applicable, use the department's person-centered planning template to develop an individual service plan that:

(i) Identifies a continuous active treatment program;

(ii) Identifies opportunities for independence, choice, and self-management;

(iii) Identifies needed developmental, behavioral, and health interventions and supports;

(iv) Identifies and promotes opportunities for community participation; and

(v) Identifies and supports preservation and development of interpersonal relationships (e.g., social contacts, relationships, and emotional supports).



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- (e) Review and revise the individual service plan as needed or upon request.
 - (f) Review implementation of the individual service plan at least quarterly and revise as needed.
 - (g) Coordinate the services, supports, and activities being provided to the individual with service providers, as identified in the individual service plan.
 - (h) 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.
 - (ii) The qualified intellectual disability professional shall document performance of the tasks described in paragraph (E)(2)(b)(i) of this rule and secure informed consent for the individual service plan from the individual, adult authorized by the individual, or the individual's guardian, as applicable.
 - (iii) The qualified intellectual disability professional shall attempt to address concerns when informed consent is refused or withdrawn by presenting alternative services or activities to the individual.
 - (iv) The individual service plan will 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 service plan; and to authorized regulatory agents. The individual service plan will not be released to other persons without the informed consent of the individual, adult authorized by the individual, or individual's guardian, as applicable.
- (c) Upon request by the department, an intermediate care facility for individuals with intellectual disabilities will provide an individual's completed person-centered planning templates as soon as possible but no later than within three business days of the request.