



PERSON
CENTERED
SERVICES

CARE COORDINATION HANDBOOK

Created 2024 | Person Centered Services

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Care Coordinator Information

Care Coordinator Name:

Care Coordinator Phone:

Care Coordinator Email:

Please leave a message with your Care Coordinator and allow your Care Coordinator up to 48 hours to return your call or email.

Supervisor Information

Supervisor Name:

Supervisor Phone:

Supervisor Email:

If you are experiencing an immediate threat to your health or safety, **call 911**.

If you are experiencing a mental health crisis, call the number for your county's crisis intervention team:

CRISIS SERVICES PHONE NUMBERS

Suicide/Crisis Lifeline

Call/text 988

Buffalo/Erie County	1-716- 834-3131
Monroe/Rochester	1-877-356-9211
Allegany County	1-888-448-3367
Cattaraugus County	1-800-339-5209
Cayuga County	1-877-356-9211
Chautauqua County	1-800-724-0461
Chemung County	1-607-442-6900
Genesee County	1-877-346-3648
Livingston County	1-877-356-9211
Niagara County	1-716-285-3515
Ontario County	1-877-356-9 211
Orleans County	1-844-345-4400
Schuyler County	1-607-442-6900
Seneca County	1-877-356-9211
Steuben County	1-607-664-2255
Wayne County	1-877-356-9211
Yates County	1-315-531-2436

*If you need Care Coordination support between 4:30pm and 8am,
call the after-hours number at **(833) 200-0678**.*

What is Care Coordination?

Care coordination helps you and your family get the services and supports you need. Care management is provided by Care Coordinators who work for Care Coordination Organizations (CCOs), organizations that were formed by developmental disability service providers (and are staffed by Care Coordinators with training and experience in the field of developmental disabilities). Your Care Coordinator will coordinate a variety of healthcare, wellness and developmental disabilities services to meet your needs.

The two care management choices are:

Health Home Care Management - The more robust, comprehensive care management service which provides:

- Coordination of the developmental disability services that you and your family need or are currently receiving, AND
- Comprehensive coordination of other health and behavioral health care services you need or receive.

Basic HCBS Plan - Focuses on planning related only to Home and Community Based Services (HCBS) and does not coordinate any other health or behavioral health services.

With this service, your Care Coordinator will work with you to:

- Develop, review and update your Life Plan (service plan),
- Ensure that your annual, needed Level of Care Eligibility Determination (LCED) is completed.

Assessments

What is the Level of Care Eligibility Determination (LCED) form?

Used by the Office for People With Developmental Disabilities (OPWDD) in New York State, this form assesses an individual's eligibility for Home and Community Based Services (HCBS) Waiver, Comprehensive Care Coordination, and other State Plan services¹.

It covers criteria related to diagnosis, disability onset, behavior problems, health care needs, adaptive behavior deficits, and more.

The LCED form helps determine whether an individual qualifies for specific services based on their needs and condition.

The form is completed to establish initial eligibility and annually to ensure the person continues to qualify for services.

What is a DDP2?

The Developmental Disabilities Profile (DDP-2) is a brief assessment used by the New York State Office for People With Developmental Disabilities to identify an individual's challenges and

service needs¹². It provides an accurate and thorough description of the skills and challenges related to developmental disabilities. If you or someone you know is going through the assessment process for OPWDD services, the DDP-2 interview helps gather information about strengths, needs, and interests.

The results of the DDP2 determine the tier level of your Care Coordination services.

What are Tier Levels of Care Coordination?

Tier Levels: There are four tier levels based on the level of support information from the Developmental Disabilities Profile 2 (DDP2):

- Tier 1: Least severe.
- Tier 2: Moderate severity.
- Tier 3: High severity.
- Tier 4: Most severe.

What Each Tier Identifies:

- **Care Coordinator/Manager (CC/CM) Caseload:** The number of individuals a Care Coordinator or manager is responsible for.
- **Rate of Payment:** The payment received by the Care Coordination Organization from New York State.
- **Required Face-to-Face Meetings:** The number of face-to-face meetings required with each individual served.

What is the Coordinated Assessment System (CAS)?

The CAS is performed through a conversation with the person with a developmental disability who is the subject of the assessment. The discussion can include either family or other people who know the person well. The CAS looks at all areas of the person's life, such as living skills, health, behavior and supports. Its purpose is to gather information to help the person, and their care planning team develop a care plan that responds to their needs.

The CAS is a three-part process that includes:

- Discussion/observation with the person with the developmental disability
- Discussion with others who know the person well (such as family members, residential support staff, Care Coordinators, Consumer Advisory Board (CAB) representatives, etc.) and
- A review of supporting documents, such as medical evaluations, etc.

The assessment process is initiated following a person's eligibility determination and repeated every two years. A CAS assessor or assessment scheduler will contact the person or their representative to set a date, time and location for a CAS interview that works for the person.

During the assessment, the trained assessor will listen to all information shared to get an idea of what the person is good at, what they need help with, what they enjoy doing and what they want from their life.

After the interview takes place, the CAS assessor will review the information gathered during this discussion, as well as any additional information provided, before the CAS process is

completed. To oversee the quality of the CAS assessments, OPWDD routinely observes CAS assessors' work. This means an OPWDD CAS Field Observer may sit in and watch the assessment meeting. The Field Observer would not actively participate in the interview but would be there to listen to and observe the assessor's process. As with any CAS assessment, the person's private information is always protected according to OPWDD's privacy practices.

Child and Adolescent Needs and Strengths Assessment (CANS)

OPWDD uses the CANS as the person-centered, consensus-based functional needs assessment for people with developmental disabilities ages 17 and younger and their families. The CANS assessment tool is designed to give a profile of the specific current needs and strengths of the child/adolescent and caregiver(s). The CANS will provide important information to the child's/adolescent's Care Coordinator (CM)/Qualified Disabilities Professional (QIDP)/those responsible for maintaining the care plan to assist with the person-centered care plan.

The CANS is a 3-part process, conducted annually by a certified CANS assessor, designed to provide the story of a child/adolescent's life. This process includes:

- Review of supporting documentation (medical evaluations, clinical assessments, Individualized Educational Plan (IEP), Life Plan, and other care plans, etc.)
- Interview with the child's/adolescent's caregiver(s)
- Interview/observation with the child/adolescent.
 - NOTE: While it is best practice to include an observation and/or interview of the child/adolescent, in some instances, it may be contraindicated or determined unnecessary.

There is a portion of the CANS that focuses on the caregiver's strengths and needs. OPWDD understands that it is important for the caregiver(s) to share their story to help understand what strengths are present, as well as supports the caregiver(s) may utilize or need to care for the child/adolescent. This information will help the CM/QIDP/those responsible for maintaining the care plan have a better understanding of what types of services may best fit with the child/adolescent and their support system. Each caregiver perspective is equally valid, and building consensus through collaboration supports more accurate assessments and stronger plans. This section of the assessment is completed, regardless of the support needs of the caregiver(s).

Care Coordinators (CM)/Qualified Disabilities Professionals (QIDP)/those responsible for maintaining the care plan may be interviewed by the CANS assessor. In some instances, especially if the child/adolescent only receives minimal services, the CM/QIDP/those responsible for maintaining the care plan may be one of the only resources for information for the child/adolescent and would need to be interviewed by the assessor. The caregiver and child/adolescent also have the option to request the CM be present during their discussion with the CANS assessor, but it is not required for the CM/QIDP/those responsible for maintaining the care plan to be present during the interview(s). The CANS assessor relies upon the CM/QIDP/those responsible for maintaining the care plan to identify the child/adolescent/caregiver(s) and support the assessor in coordinating interviews, as needed. The CM/QIDP/those responsible for maintaining the care plan ensure that the CANS assessor has access to all supporting documentation for review, prior to the CANS interview(s).

After the CANS has been completed by the CANS assessor, it is electronically transferred within 48 hours to the person's record in the OPWDD computer system, CHOICES. The CM/QIDP/those

responsible for maintaining the care plan will review the CANS report summary with the caregiver(s) and child/adolescent, as well as additional support providers (i.e., residential provider), as appropriate and within 30 days of availability. At this time, the caregiver/child/adolescent and other supports may provide any other information they would like included in the child's/adolescent's care plan.

The CANS Summary, also referred to as the Strengths and Needs Report, will be used to create the care plan. This provides the CM/QIDP/those responsible for maintaining the care plan with information about the child/adolescent's needs, strengths, interests, and available and current natural supports. Details provided in the Strengths and Needs Report will help the CM/QIDP/those responsible for maintaining the care plan to expand on information already known about the child/adolescent or identify areas that require further exploration or assessment for the ongoing development of the care plan.

What is the PATHS assessment?

OPWDD's Personalized Assessment Tool for Health Services (PATHS) is part of the process to determine eligibility for OPWDD services. The purpose of the assessment is to identify the current strengths and needs of the individual and the natural or community supports they have or can get. The information gathered from the assessment is used to plan for services and to develop a person-centered plan.

What is Person-Centered Planning?

Person-Centered Planning is the way you and your Care Coordinator explore your needs and wants---what is important to you, how you want to live, and how OPWDD can provide the support to help you get there. The Person-Centered Planning process is directed by you and the people important to you, usually including your family members. The focus is on your abilities, capacities, interests, and what you are looking for in your life. By providing supports and services planned around your needs and goals, OPWDD can help you reach your potential and live a fulfilling life.

Focus on Outcomes!

The results of the planning and services provided—the outcomes—are what really matter. Outcomes are not goals but tell us whether a person's goals are being achieved. The planning and supports provided should work for you and your family. To find out if they do, we look at the results and ask questions like:

- Are you connected to activities that are important to you?
- Are the supports helping you develop and maintain relationships that are important to you?
- Do you feel safe and stable? Developing a plan for your supports and services is only the first step. We continually work with you to make sure the plan meets your needs and revise it as necessary.

Students Transitioning from School to OPWDD

OPWDD wants families to know that we need your help to make sure there is no break in service for children finishing their school program. Local school districts provide special education

services until a student graduates or completes their school program at the end of the school year in which they turn age twenty-one (21). Schools are expected to help plan the student's transition to adult services before their 15th birthday. Families also should begin the process of determining OPWDD eligibility and planning for services ahead of time. If your child is older than fifteen, you are encouraged to start the process as soon as possible. This allows time to find the best supports, develop a plan, and do so at a more relaxed pace.

OPWDD's Front Door staff, working with Care Coordinators, will help students at local schools plan for the OPWDD supports they may need as adults. Please ask your Front Door team representative for more information. If your child attends a residential school (as a result of a school placement and is graduating or completing their school program at the end of the school year in which they turn 21), OPWDD's Residential School Transition Coordinators help you and your child work with not-for-profit service provider agencies to plan for and carry out your child's transition.

Your Life Plan

Your Care Coordinator will work with you and your family/Circle of Support to develop your Life Plan, an individualized service plan designed just for you. Your Life Plan is a roadmap to your personal goals and describes the supports and services that will help get you there.

Developing Your Life Plan

Your Care Coordinator:

- Develops your Life Plan using a person-centered approach, working with you, and other people you and your family think should be involved.
- Helps you make informed choices and develop a personal network of activities, supports, services, and community resources based on your needs and desires.
- Documents the supports, services and community resources needed and chosen by you, and details how you will access them in your Life Plan
- Helps you identify the additional Care Coordination activities and interventions that you want and need to meet your individualized goals and valued outcomes as described in your Life Plan

Implementing Your Life Plan

To implement your Life Plan, your Care Coordinator:

- Shares his or her knowledge of the community and researches available resources to help you make informed choices about how to achieve your valued outcomes.
- Makes referrals and facilitates visits and interviews with family members, service providers, housing options, and other alternatives so that you can make informed choices.
- Coordinates access to and delivery of supports and services identified in your Life Plan, including both natural supports and funded services.

OPWDD Supports and Services

OPWDD is committed to providing a wide variety of support and service options to meet your needs. OPWDD supports and services include:

- Help to live independently in the community with rent subsidies, community habilitation and other services
- Help for your family to support you in the family home with respite and family support services
- Help with employment training and support, volunteer opportunities and other types of community activities you choose, and
- Intensive residential and day services, if needed

OPWDD is committed to helping you obtain the supports and services that most closely match your preferences. Please keep in mind that OPWDD serves individuals in the most community-integrated setting possible.

The supports and services you choose may come from several different sources. You may get help from family, friends and neighbors, and you may participate in programs that help you to be part of your community. This kind of assistance is referred to as “natural and community supports.” OPWDD’s goal is to provide services that add to those natural and community supports to help you accomplish your goals and valued outcomes.

Self-Direction of Supports & Services

You may choose to self-direct your supports and services. Self-Direction empowers you and your family to choose the supports and services that best fit your needs. Self-Direction can provide you with more flexibility and gives you the maximum amount of control over your supports and services. Through Self-Direction, services are paid for with funds from your Personal Resource Account (PRA). The PRA is a budget amount based on your assessed needs. The dollar amount varies for each person. You can self-direct some or all of your services.

If you self-direct your services, you will be helped by your Circle of Support, the group of people you choose who work with you to help you make your best decisions and support your success. Remember, Circles of Support can be as small as a few people, or they can be large. You are at the “center” of your circle, and members connect on an ongoing basis to discover, discuss and help you plan the best way to meet your needs and fulfill your personal goals.

Employer and Budget Authority

You may choose to exercise decision-making authority over some or all your services. By exercising this choice, you also accept the responsibility for taking a direct role in managing these services. You will be helped to do this by your Circle of Support.

Employer Authority allows you to be responsible for hiring staff who will provide your supports and services. You co-manage staff with a provider agency that can help you with recruiting, supervising and directing support workers, or you can handle some or all these responsibilities yourself. The provider agency also supports you by providing functions such as screening potential employees and handling payroll. These are some, but not all, of the potential responsibilities.

Budget Authority allows you to take responsibility for managing your individualized Self Direction budget. This authority lets you make decisions about the supports and services included in your Life Plan, who is paid to provide them, and how they are purchased. Budget authority also allows you to self-hire your staff and gives you control over how much your staff are paid. If you choose to have Budget Authority, your Fiscal Intermediary will help you by billing and making payments for approved self-directed supports and services, and by providing fiscal accounting and reporting and general administrative supports.

Independent Living in the Community – Apartments & Housing

OPWDD offers housing supports and services based on the goals and needs of each person, supporting people to live in the most integrated community setting possible. While it is often seen as more common for people with milder disabilities to live independently in the community, individuals with moderate to very severe disabilities have also been successful at living in apartments and their own homes in the broader community with the right supports and services.

Community living can be extremely rewarding and can help you reach your potential. Staff, family and friends may help you live successfully in the community.

The Individual Supports and Services (ISS)/Housing Subsidy helps adults with developmental disabilities live in their communities by providing funds to help you pay for rent and utilities in your own apartment in the community. Housing subsidies are available to help individuals live independently – you can share an apartment with one or more people who are not your parents or legal guardians. For more information, visit the OPWDD website below:

opwdd.ny.gov/opwdd_community_connections/housing_initiative/opwdd-housingsubsidy

Community Residential Settings

Community residential settings in the OPWDD system are certified homes that offer different levels of support to individuals with developmental disabilities who have high needs.

Family Care provides community-based housing in private homes that are approved and certified by OPWDD. The Family Care program offers a caring and stable home environment in a family-like setting.

IRAs (Individualized Residential Alternatives) or Group Homes, provide room, board and individualized services and supports in a home-like setting where individuals with developmental disabilities can gain the skills they need to live as independently as possible. Some people who

live in IRAs need help 24/7 to meet their medical and behavioral needs. Other people who live in IRAs need less support.

Employment and Day Services

OPWDD values the abilities and talents each person contributes and supports people with developmental disabilities in preparing for working and volunteering in integrated community settings. In addition, OPWDD provides support and services for individuals so that they can participate in community activities that interest them. Individuals who participate in day services can also participate in employment services.

Prevocational Services

OPWDD prevocational services offer people with developmental disabilities an opportunity for career exploration and volunteer experiences to identify their skills, abilities and interests.

Pathway to Employment is a time-limited service that helps you develop a plan for employment success using Person-Centered Planning to identify your job interests and goals, try various jobs to determine which tasks and work atmosphere you like best, and learn work-related social and communications skills. The outcome of this service is a Career and Vocational Plan that identifies the next step in your path to employment.

You may be eligible for Pathway to Employment if you are receiving day habilitation or community prevocational services, or are a student leaving high school, or someone who is interested in creating a career and vocational plan.

Community Prevocational Services help people with developmental disabilities learn social and communication skills related to work as well as other work-related skills such as task completion, time management, problem solving, following directions and safety skills that will increase their independence in the community.

Employment Services

OPWDD employment services can help people with developmental disabilities obtain and maintain competitive employment. People with developmental disabilities work in all types of community businesses including banking, education, technology, health care, hospitality, food service, retail, not-for-profit corporations and government. Some people have also started their own businesses. OPWDD offers several employment services to assist individuals with varying support needs. All employment services provide employment staff or job developers and coaches to help individuals with developmental disabilities be successful at work.

Supported Employment (SEMP) supports people in getting and keeping paid competitive jobs in the community. Once a person-centered career plan is developed through Pathway to Employment, Community Prevocational Services or another method, OPWDD service provider agencies offer job development services. OPWDD service provider agencies also offer services to assist with maintaining employment. These services include helping the individual adapt to the workplace, retraining when job requirements change, and travel training.

The Employment Training Program (ETP) offers people an opportunity to work in a paid internship in a community business. ETP participants receive enhanced job coaching and attend job readiness classes that cover topics like conflict resolution and how to dress for work.

Day Services

OPWDD day services help people with developmental disabilities increase their independence, gain self-confidence and develop relationships in their community.

Community Habilitation (CH) helps people who live independently or at home with family learn about and experience community-based activities. Community Habilitation is a service available at home and in the community. It can be either self-directed or agency sponsored. Community Habilitation staff help the person learn and keep the skills they need to live safely and more independently, maintain or improve their health, work toward other personal goals, meet people and make and keep friends, take part in community activities, and be part of their community.

Day Habilitation services help people learn and keep the skills they need to live safely and more independently, participate in community activities, identify interests, develop talents and skills, make and keep friends, learn basic life skills, and be a valued member of the community. Day Habilitation activities take place at a set location or within the community (referred to as **Day Habilitation Without Walls**).

Respite services help families who care for their loved ones in the family home, even if the individuals have more serious health issues or more challenging behavioral needs. These services give caregivers needed breaks. The kinds and locations of respite service available include **in-home, camp, recreational and site based**.

Family Support Services

Family Support Services help families who care for their loved ones at home. These services can provide needed breaks to caregivers, training and moral support, recreational and social activities, sibling services, parent-to-parent networking and Front Door access to services in times of crisis.

Family Support Services include:

- Respite (provides relief to individuals who are responsible for the primary care and support of an individual with a developmental disability)
- Family member training
- Support groups
- Training in how to manage challenging behaviors
- Reimbursement
- Parent-to-parent networking
- Information and referral
- Sibling services
- After school programs
- Recreation/social activities

Assistive Technology and Medical and Behavioral Health

Assistive Technology is a category of services that encompasses both environmental modifications (e-mods) and adaptive technology.

OPWDD is not a primary provider of medical services or durable medical equipment but offers supports designed to foster behavioral health. OPWDD also operates clinics with limited services.

Environmental Modifications (e-mods) and Adaptive Technology

Environmental Modifications include physical changes to the home such as a ramp and can include modifications that address the individual's sensory deficits or promote a safer environment for individuals with challenging behaviors.

Adaptive technology includes communication aids and adaptive devices, including aids for feeding, dining and meal preparation as well as other tools to help a person live as independently as possible. Van modifications to meet specialized transportation needs are also included.

Intensive Behavioral Services are short-term services of about six months that focus on developing effective behavior support strategies for people whose challenging behavioral issues put them at risk of placement in a more restrictive residential setting (such as a group home or hospital). This program teaches individuals, family members and other caregivers how to respond to challenging behaviors. To be eligible for these services, the individual must live in their own home, their family's home, or a Family Care home, and be enrolled in the Home and Community-Based Services waiver.

New York Systemic, Therapeutic, Assessment Resources and Treatment/Crisis Services for Individuals with Intellectual and/or Developmental Disabilities (NYSTART/CSIDD) is a community-based program that provides crisis prevention and response services to individuals with intellectual and developmental disabilities who have complex behavioral and mental health needs, and to their families and others in the community who provide support to them. The NY START/CSIDD program offers training, consultation, therapeutic services and technical assistance to help individuals remain in their home.

Clinic Services

OPWDD is not a primary provider of medical services but does operate clinics with limited services. OPWDD clinics were established to meet the needs of individuals with developmental disabilities in areas where there are not enough generic providers of medical services. OPWDD clinics also provide services to individuals with very complex needs.

Groups to Support You

What is Self-Advocacy?

Self-advocacy is especially important for people with intellectual and developmental disabilities (I/DD). It empowers individuals to express their needs, make informed decisions, and assert their rights.

Here are three key aspects of self-advocacy:

1. **Know Yourself:**
 - Understand your strengths, challenges, and goals.
 - Learn about your rights and where to seek support.

2. **Speak Up:**
 - Advocate for what you need and want.
 - Examples include requesting equal opportunities at work or making personal decisions.

3. **Empowerment:**
 - Self-advocacy enhances confidence and quality of life.
 - It emphasizes political power and self-determination.
 - People who self-advocate are better equipped to express feelings and make decisions.

For more resources on services and supports, visit The Knowledge Center at knowledgecenterny.com.



For more information from OPWDD, visit opwdd.ny.gov.

