

SUBSTANCE USE DISORDER  
RESIDENTIAL REHABILITATION SERVICES FOR YOUTH (RRSY)  
TITLE 14 NYCRR PART 817

[Statutory Authority: Mental Hygiene Law Sections 19.07(e), 19.09(b), 19.15(e),19.40, 32.01, 32.07(a)and  
32.09]

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**817.1 Legal base**

- (a) Section 19.07(e) of the Mental Hygiene Law authorizes the Commissioner of the Office of Alcoholism and Substance Abuse Services to adopt standards including necessary rules and regulations pertaining to chemical dependence services.
- (b) Section 19.09(b) of the Mental Hygiene Law authorizes the Commissioner of the Office of Alcoholism and Substance Abuse Services to adopt regulations necessary and proper to implement any matter under their jurisdiction.
- (c) Section 19.15(e) of the Mental Hygiene Law authorizes the Commissioner to implement programs of children and youth.
- (d) Section 19.40 of the Mental Hygiene Law authorizes the Commissioner of the Office of Alcoholism and Substance Abuse Services to issue operating certificates for the provision of chemical dependence services.
- (e) Section 32.01 of the Mental Hygiene Law authorizes the Commissioner of the Office of Alcoholism and Substance Abuse Services to adopt any regulation reasonably necessary to implement and effectively exercise the powers and perform the duties conferred by Article 32 of the Mental Hygiene Law.
- (f) Section 32.07(a) of the Mental Hygiene Law authorizes the Commissioner of the Office of Alcoholism and Substance Abuse Services to adopt regulations to effectuate the provisions and purposes of Article 32 of the Mental Hygiene Law.
- (g) Section 32.09 of the Mental Hygiene Law authorizes the Commissioner to issue operating certificates for services that treat chemically dependent individuals.

- (h) Section 3309 of the Public Health Law authorizes the DOH to establish standards for approval of any opioid overdose prevention program.
- (i) Section 2781 of the Public Health Law defines the rules governing HIV testing in New York.

**817.2 General program standards**

(a) *Policies and procedures.* The program sponsor must approve written policies, procedures and methods governing the provision of services to patients in compliance with Office regulations including a description of each service provided and the overall approach to service delivery and a description of evidence-based practices employed in group, individual and family treatment. Such policies and procedures shall address, at a minimum, the following:

- (1) procedures and specific criteria for admission, retention, transfer, referrals and discharge;
- (2) level of care determinations utilizing the OASAS level of care determination protocol, treatment/recovery plans, and placement services;
- (3) staffing, including but not limited to, training, supervision, and use of student interns, peers, and volunteers;
- (4) the provision of medical and psychiatric services, including screening and referral for associated physical or mental health conditions;
- (5) a schedule of fees for services rendered;
- (6) infection control procedures;
- (7) cooperative agreements with other substance use disorder services providers and other providers of services that the patient may need;
- (8) compliance with other requirements of applicable local, state and federal laws and regulations, OASAS guidance documents and standards of care regarding, but not limited to:
  - (i) education, counseling, prevention and treatment of communicable diseases, including viral hepatitis, sexually transmitted diseases and HIV/AIDS; regarding HIV, such education, counseling, prevention and treatment shall include condom use, testing, pre- and post-exposure prophylaxis and treatment;
  - (ii) the use of alcohol and other drug screening and toxicology tests; and
  - (iii) medication and the use of medication assisted treatment;
  - (iv) if acupuncture is provided it must be provided in accordance with Part 830 of this Title;
  - (v) the use of a problem gambling screen approved by OASAS.

(9) record keeping procedures which ensure that documentation is accurate, timely, prepared by appropriate staff, and in conformance with the federal confidentiality regulations contained in 42 Code of Federal Regulations Part 2; and

(10) Utilization review and quality improvement. All programs must have a utilization review process, a quality improvement committee, and a written plan that identifies key performance measures.

(11) Providers must comply with all applicable laws regarding the use of restraint and seclusion.

(b) *Program goals.* The program shall have as its goals:

(1) the improvement of functioning and development of coping skills necessary to enable the patient to be safely, adequately and responsibly treated in the least intensive environment; and

(2) the development of individualized plans to support the maintenance of recovery, attain self-sufficiency, and improve the patient's quality of life.

(c) *Minimum services.* An array of services shall be provided including, but not limited to, those listed below. The services must be clinically indicated and specified in the individualized treatment/recovery plan.

(1) Clinical services including:

(i) Counseling services: trauma-informed individual, group and family counseling as appropriate; Group counseling sessions must be structured in size and duration to maximize therapeutic benefit for each participant. Program policies must include a process for determining group size, group purpose, monitoring patient experience, and assessing group efficacy; activities therapy;

(ii) Assessment and referral services for patients and significant others;

(iii) Medical and psychiatric consultation;

(iv) HIV and AIDS, hepatitis C, tuberculosis, and other communicable diseases education, risk assessment, supportive counseling and referral;

(2) Recovery support services including:

(i) chemical dependence awareness and re-occurrence prevention;

(ii) education about, orientation to, and the opportunity for participation in, available and relevant self-help and sober/peer support groups including Alternative Peer Groups;

(iii) holistic health practices; socialization skills;

(3) Educational assessment and educational services, as appropriate and as required by law, either directly or by arrangement with local school districts including:

(i) Vocational assessment and vocational services;

(ii) life skills training.

(d) *Medication Assisted Treatment.* A program must provide services to an individual who is receiving approved opiate full agonist maintenance or detoxification. Opiate maintenance or detoxification services must be provided through a written agreement with an appropriately certified outpatient provider of opioid full agonist treatment in accordance with applicable federal and state requirements including, but not limited to, regulations of the federal Center for Substance Abuse Treatment, the United States Drug Enforcement Administration, the New York State Department of Health, and Part 822 of this Title.

(e) *Emergency medical kit.* Pursuant to Part 800 of this Title, all programs must maintain an emergency medical kit at each certified or funded location; such kit must include basic first aid and at least one naloxone emergency overdose prevention kit. Programs must develop and implement a plan to have staff trained in the prescribed use of a naloxone overdose prevention kit such that it is available for use during all program hours of operation.

(1) All staff and patients should be notified of the existence of the naloxone overdose prevention kit and the authorized administering staff.

(2) Nothing in this regulation shall preclude patients from becoming authorized in the administration of the naloxone emergency overdose prevention kit, provided however, the program director must be notified of the availability of any additional authorized users.

(f) *Food and nutrition.* (1) Each facility shall provide to each patient three (3) nutritious meals each day which furnish sufficient nutrients and calories to meet normal needs as well as the special needs of persons in recovery.

(2) The facility shall have available snacks and beverages between meals.

(3) A dietician or dietetic technician acting within their scope of practice shall provide menu planning services. Other suitable staff shall be responsible for the procurement of food supplies and the training and directing of food preparation and serving personnel.

(g) *Certified capacity.* The certified bed capacity of each RRSY program shall not be exceeded at any time except with the written approval of the Office.

(h) *Medicaid.* Providers seeking Medicaid reimbursement must comply with the requirements of Part 841 of this Title.

(i) *Segregation.* All patients must at all times be kept physically separated from patients of non-Part 817 services. In accordance with a provider-specific plan approved by the Office prior to implementation, certain groups of patients shall be kept physically separated within the facility based upon clinically appropriate age, gender and developmental grouping.

(k) *Telepractice.* Services may be delivered using telepractice consistent with Part 830 of this Chapter.

### **817.3 Admission procedures**

(a) *Initial determination.* (1) An individual who appears at the service seeking treatment or evaluation shall have an initial determination made and documented in a written record by a qualified health professional, or other clinical staff under the supervision of a qualified health professional, which states the following:

(i) that the individual is documented as less than 21 years of age on the date of admission and appears to be in need of chemical dependence services;

(ii) that the individual appears to be free of serious communicable diseases that can be transmitted through ordinary contact; and

(iii) that the individual appears not to be in need of acute hospital care, acute psychiatric care, Part 816 crisis services or other services which cannot be provided in conjunction with treatment at the facility or would prevent them from participating in substance use disorder treatment.

(2) The initial determinations made pursuant to the above shall be based upon provider records, reports from other providers and face-to-face contact with the individual, all of which must be documented.

(b) *Level of care determination.* If an individual is determined to be appropriate for substance use disorder treatment services, a level of care determination utilizing the OASAS level of care determination protocol, shall be made by a clinical staff member. The level of care determination shall be made no later than one patient day after the patient's first on-site visit to the program and documented in the patient record.

(c) *Prohibition against discrimination.* No individual shall be denied admission to the service based solely on the individual's:

(1) prior treatment history;

(2) referral source;

(3) pregnancy;

(4) history of contact with the criminal justice system;

(5) HIV and AIDS status;

(6) physical or mental disability; or

(7) lack of cooperation by significant others in the treatment process.

(d) *Additional requirements for the admission of Medicaid eligible individuals.* A provider must obtain pre-admission approval as follows prior to admitting Medicaid eligible individuals to the program.

(1) The Office shall establish a pre-admission review team ("ART") that shall use the requirements of this Section to review each individual candidate to determine their appropriateness for admission. If deemed appropriate for admission, the ART shall certify that the individual seeking admission is in need of this level of

residential treatment for chemical dependence. The ART shall be operated in accordance with the procedures established by the Office and shall at a minimum consist of a Physician, a Social Worker licensed and currently registered as such by the New York State Education Department, and a Credentialed Alcoholism and Substance Abuse Counselor.

(2) Except in emergency circumstances, the service provider must obtain approval from the ART prior to admitting a Medicaid eligible individual. Emergency admissions are authorized only when an individual appears for treatment meeting the admission criteria and meets one of the following conditions:

- (i) the individual has a history of re-occurrence outside of a structured 24-hour setting;
- (ii) the individual is unable to access transitional services in the community; or
- (iii) the individual is without appropriate housing.

(3) Under no circumstances should an individual be admitted on an emergency basis or otherwise if they are in medical or psychiatric crisis or if they are in need of withdrawal services and an appropriate referral for such services is made.

(e) *Admission criteria.* (1) To be admitted to the program it must be determined that ambulatory services in the community do not meet the needs of the individual recipient or the individual's environment is not conducive to recovery.

(2) If the individual is deemed inappropriate for service, unless the individual is already receiving chemical dependence services from another provider, a referral and connection to a more appropriate service provider shall be made. The reasons for denial of admission must be provided to the individual and documented in a written record maintained by the service provider.

(3) The decision to admit shall be made by a staff member who is a qualified health professional authorized by the program sponsor to admit individuals. The name of the qualified health professional who made the admission decision, along with the date of admission, must be documented in the patient record.

(4) There must be a notation in the case record that the patient received a copy of the program's rules and regulations, including patient rights and a summary of federal confidentiality requirements, and a statement that notes that such rules were discussed with the patient, and that the patient indicated that they understood them.

(5) All prospective patients must be informed that admission to a program is on a voluntary basis and a prospective patient is free to discharge themselves from the service at any time. For prospective patients under an external mandate, the potential consequences for premature discharge must be explained, including that the external mandate does not alter the voluntary nature of admission and continued treatment.

(6) Individuals under the age of eighteen may be admitted without the consent of a parent or legal guardian under certain circumstances in accordance with Mental Hygiene Law Section 22.11.

#### **817.4 Post Admission Procedures**

(a) *Post-admission.* (1) As soon as possible after admission, for all patients, all programs must:

(i) offer viral hepatitis testing; testing may be done on site or by referral;

(ii) offer HIV testing; testing may not be conducted without patient written informed consent except in situations specifically authorized by law; testing may be done on site or by referral; individuals on a regimen of pre- or post-exposure prophylaxis, must be permitted to continue the regimen until consultation with the prescribing professional occurs.

(2) If clinically indicated, all programs must:

(i) conduct an intradermal skin or blood-based Tuberculosis test; testing may be done on site or by referral with results as soon as possible after testing; for patients with a positive test result, refer the patient for further tuberculosis evaluation.

(ii) offer testing for other sexually transmitted diseases; testing may be done on site or by referral;

(iii) provide or recommend any other tests the examining physician or other medical staff member deems to be necessary including, but not limited to, an EKG, a chest X-ray, or a pregnancy test.

(3) As soon as possible after testing programs must explain any blood and skin test results to the patient.

(b) *Initial evaluation.* (1) The goal of the initial evaluation shall be to obtain information from such sources, including family members where appropriate, as necessary to develop an individualized patient-centered treatment/recovery plan.

(2) No later than three (3) days after admission, staff shall complete the initial evaluation which shall include a written report of findings and conclusions and shall include the names of any staff participating in the evaluation and be signed by the qualified health professional responsible for the evaluation.

(c) *Initial services.* The initial evaluation shall include an identification of initial services needed, and schedules of individuals and group counseling to address the needed services until the development of the treatment/recovery plan. The initial services shall be based on goals the patient identifies for treatment and shall include substance use and any other priority issues identified in the admission assessment and initial evaluation.

(d) *Medical history.* (1) For those patients who have not had a physical examination or mental health history taken within one year prior to admission, each such patient must either be assessed face-to-face by a member of the medical staff to ascertain the need for a physical examination or referred for a physical

examination. For those patients who have had a physical examination within one year prior to admission, or for those patients being admitted directly to the outpatient program from another chemical dependence service authorized by the Office, the existing medical history and physical examination documentation may be used to comply with the requirements of this subdivision, provided such documentation has been reviewed by a medical staff member and determined to be current. Notwithstanding the foregoing, the following shall be offered regardless of a documented history within the previous twelve months: HIV and viral hepatitis testing.

(2) Patient records shall include a summary of the results of the physical examination and shall also demonstrate that appropriate medical care is recommended to any patient whose health status indicates the need for such care.

(e) *Referral and connection* (1) If the initial evaluation and medical history indicates that the individual needs services beyond the capacity of the program to provide either alone or in conjunction with another program, referral and connection to appropriate services shall be made. Identification of such referrals and the results of those referrals to identified program(s) shall be documented in the patient record.

(2) If a patient is referred directly to the program from another service provider certified by the Office, or is readmitted to the same service provider within sixty (60) days of discharge, the existing level of care determination and initial evaluation may be used, provided that documentation is maintained demonstrating a review and update.

### **817.5 Treatment / recovery plan**

(a) *Treatment / recovery plan.* Each patient must have a written patient-centered treatment/recovery plan developed by clinical staff and patient as soon as possible after admission but not later than ten (10) calendar days after admission. Standards for developing a treatment/recovery plan include, but are not limited to:

(1) The treatment/recovery plan must also be developed in consultation with the patient's parent or guardian unless the minor is being treated without parental consent as authorized by Mental Hygiene Law section 22.11.

(2) For patients moving directly from one program to another, the existing treatment/recovery plan may be used if there is documentation that it has been reviewed and, if necessary, updated within ten (10) days of transfer.

(b) *Treatment/recovery plan.* The treatment/recovery plan must:

(1) include each diagnosis for which the patient is being treated;



(2) address patient identified problem areas specified in the admission assessment and concerns which may have been identified subsequent to admission, and identify methods and treatment approaches that will be utilized to achieve the goals developed by the patient and primary counselor;

(3) identify a single member of the clinical staff responsible for coordinating and managing the patient's treatment who shall approve and sign (physical or electronic signature) such plan; and

(4) be reviewed, approved, signed and dated by the physician within fourteen (14) days after admission.

(5) Where a service is to be provided by any other program off-site, the treatment/recovery plan must contain a description of the nature of the service, a record that referral for such service has been made, and the results of the referral.

(c) *Continuing review of treatment plans.* (1) The clinical staff shall ensure that the treatment/recovery plan is included in the patient record and that all treatment is provided in accordance with the individual treatment/recovery plan.

(2) If, during the course of treatment, revisions to the treatment/recovery plan are determined to be clinically necessary, the plan shall be revised accordingly by the clinical staff member.

(3) The treatment/recovery plan must be reviewed, and revised if necessary, at least once within every 30 calendar days from the date of admission. Reviews should occur more frequently when a patient is not responding to treatment as planned or if a significant incident occurs. Reviews of the treatment plan shall be signed (physical or electronic signature) by a physician.

(d) *Progress notes.* (1) A progress note shall be written, signed and dated by the clinical staff member or another clinical staff member familiar with the patient's care no less often than once per week. Such progress note shall provide a chronology of the patient's participation in all significant services provided, their progress related to the initial services or the goals established in the treatment/recovery plan and be sufficient to delineate the course and results of treatment/services.

(e) *Discharge and planning for level of care transitions.* (1) The discharge planning process shall begin as soon as the patient is admitted and shall be considered a part of the treatment planning process. The plan for discharge and level of care transitions shall be developed in collaboration with the patient and any significant other(s) the patient chooses to involve. If the patient is a minor, the plan must also be developed in consultation with the patient's parent or guardian, unless the minor is being treated without parental consent as authorized by Mental Hygiene Law Section 22.11.

(2) Discharge should occur when:

(i) the patient meets criteria documented by the OASAS level of care determination protocol for an alternate level of care and has attained skills necessary to identify and manage cravings and urges to use

substances, stabilized psychiatric and medical conditions, and has identified a plan for returning to their community;

(ii) the patient has received maximum benefit from the service provided by the program; or

(iii) the individual is disruptive and/or fails to comply with the program's reasonably applied written behavioral standards, provided the individual is offered a referral to another treatment program.

(3) No patient shall be discharged without a discharge plan which has been completed and reviewed by the multi-disciplinary team prior to the discharge of the patient. This review may be part of a regular treatment/recovery plan review. The portion of the discharge plan which includes the referrals for post-discharge shall be given to the patient. This requirement shall not apply to patients who leave the program without permission, refuse continuing care planning, or otherwise fail to cooperate.

(4) The discharge plan shall be developed by the clinical staff member, who, in the development of such plan, shall consider the patient's self-reported confidence in maintaining their health and recovery and following an individualized re-occurrence prevention plan. The clinical staff member shall also consider an assessment of the patient's home and family environment, vocational/educational/employment status, and the patient's relationships with significant others. The purpose of the discharge plan shall be to establish the level of clinical and social resources available to the individual post-treatment and the need for the services for significant others. The plan shall include, but not be limited to, the following:

(i) identification of any other treatment, rehabilitation, self-help and vocational, educational and employment services the patient will need after discharge;

(ii) identification of the type of residence, if any, that the patient will need after discharge;

(iii) identification of specific providers of these needed services;

(iv) specific referrals and initial appointments for these needed services; and

(v) the patient, and their family/significant other(s) shall be offered naloxone education and training and a naloxone kit or prescription.

(5) A discharge summary which includes the course and results of care and treatment must be prepared and included in each patient's case record within twenty (20) days of discharge.

## **817.6 Patient records**

(a) *Case Records.* (1) Programs must maintain individual case records for each patient served. Patient records maintained by inpatient services are confidential and may only be disclosed in conformity with federal regulations regarding the confidentiality of records related to persons receiving treatment for substance use disorder as set forth in 42 Code of Federal Regulations Part 2, or other applicable law.

(2) There shall be a single individual record for each person admitted to the program which shall include, at a minimum:

- (i) identifying information about the patient and their family;
- (ii) the source of referral, date of commencing service and name of primary counselor;
- (iii) the admission diagnosis, including chemical dependence-related, medical, and psychiatric diagnoses in official nomenclature with associated diagnostic codes;
- (iv) reports of all evaluations performed, including findings and conclusions;
- (v) reports of all examinations performed, including but not limited to X-rays, clinical laboratory tests, clinical psychological tests, electroencephalograms, and psychometric tests;
- (vi) the written and signed individual treatment plan, including all reviews and updates;
- (vii) progress notes informative of the patient's condition and response to treatment, written and signed by staff members;
- (viii) summaries of case conferences, treatment plan updates, and special consultations and communications held;
- (ix) dated and signed prescriptions or orders for all medications with notation of termination dates;
- (x) the discharge and level of care transitions plan;
- (xi) any other documents or information regarding the patient's condition, treatment, and results of treatment; and

(xii) signed forms consenting to treatment and for obtaining or releasing confidential information in accordance with 42 Code of Federal Regulations Part 2 or other applicable law.

(b) *Disclosures.* Disclosure of HIV and AIDS related information contained in a patient's record shall be made in accordance with the Article 24 of the Public Health Law, other applicable state and federal statutes and regulations, and subject to the additional disclosure requirements of 42 Code of Federal Regulations Part 2.

(c) *Reporting to Office.* Statistical information shall be reported to the Office as required and on the prescribed forms therefor.

### **817.7 Staffing**

(a) *Medical Director and medical staff.* (1) The medical director, as defined in Part 800 of this Title, shall oversee the development and revision of medical policies, procedures and ongoing training for matters such as routine medical care, specialized services, and medical and psychiatric emergency care, and supervision of medical staff.

(2) Programs providing treatment for persons with co-existing medical or psychiatric conditions in addition to their substance use disorder shall have an appropriately qualified physician, physician's assistant, nurse practitioner, psychiatrist or psychologist on-site or through telepractice, pursuant to Part 830 of this Title, for a sufficient number of hours each week to provide evaluation, treatment and supervision of such other services for these patients.

(3) There shall be at least one full-time registered professional nurse and additional licensed practical nurses, registered nurses, registered physician's assistants, and nurse practitioners sufficient to provide the services required. Such personnel shall be available to all patients at all times.

(4) The medical director may also serve as a physician of another service which is provided by the facility. The general severity of the condition of the population served, including comorbid conditions, complications and general functioning, may indicate the need for staff in addition to those identified in this section.

(b) *Staff sharing.* Staff may be either specifically assigned to the inpatient service or may be part of the staff of the facility within which the inpatient service is located. However, if these staff members are part of the general facility staff, they must have specific training and experience in the treatment of substance use disorder specific to the services provided. The percentage of time that each shared staff is assigned to the inpatient service must be documented.

(c) *Supervision and training.* Each program must provide clinical supervision and ensure and document a plan for staff training based on individual employee needs. Subject areas appropriate for training shall be identified by the Office.

(d) *Program director.* There shall be a director of the program who is a qualified health professional with at least:

(1) four (4) years experience in the human services field;

(2) two (2) years experience in the provision of substance use disorder treatment services;

(3) two (2) years of administration and supervisory experience prior to appointment as director; and

(4) two (2) years of adolescent services experience.

(e) *Other clinical staff.* (1) At least 50 percent of all clinical staff shall be qualified health professionals as defined in Part 800 of this Title. CASAC Trainees may be counted towards satisfying the 50 percent requirement provided, however, that such individuals shall not be considered qualified health professionals for any other purpose under this Part.

(2) Clinical staff members who are not qualified health professionals shall have qualifications appropriate to their assigned responsibilities as set forth in the inpatient service's written personnel policies,

shall be subject to appropriate staff supervision, and shall receive regular and continuing education and training.

(3) There shall be at least one clinical staff member, as defined in Part 800 of this Title, designated to provide activities therapy;

(4) There shall be at least one counselor for every eight (8) patients, at least 50 percent of whom shall be qualified health professionals. Counseling staff shall be scheduled for a minimum of one and one-half shifts five days per week, and one shift per day for the remaining two days per week;

(5) There shall be clinical staff available to all patients at all times. During late evening and night shifts, there shall be at least two clinical staff members on duty. This staff shall be awake at all times, make frequent rounds and be available to patients who awaken during the night;

(6) There shall be at least one full time equivalent Licensed Mental Health Counselor or Social Worker licensed and currently registered as such by the New York State Education Department experienced in chemical dependence and adolescents. If qualified to do so, this individual may also perform the family therapist function required in paragraph (7) below.

(7) There shall be at least one full time equivalent Family Therapist who is a Social Worker licensed and currently registered as such by the New York State Education Department or a licensed Marriage and Family Therapist. If qualified to do so, this individual may also perform the social worker function required in paragraph (6) above.

(8) There shall be sufficient clinical staff to achieve an overall ratio of at least one full time equivalent staff for each four (4) patients.

(f) *Additional required staff.* (1) Maintenance and security. There shall be sufficient staff available to ensure that the program facility and all equipment utilized therein is maintained in such a manner as to provide patients with a clean and safe environment.

(2) Volunteers and interns. In addition to staffing requirements of this Part, a program may utilize volunteers, students and trainees, on a salaried or non-salaried basis. Such personnel shall be provided close professional staff supervision and appropriate education from both internal and external sources.

(3) Health coordinator. Each program shall have a qualified individual designated as the Health Coordinator who will ensure the provision of education, risk reduction, counseling and referral services to all patients regarding HIV and AIDS, tuberculosis, hepatitis, sexually transmitted diseases, and other communicable diseases.

(4) Community Support Specialist. There shall be at least one Community Support Specialist for every

thirty (30) patients or portion thereof who shall be responsible for coordinating care for the patient and assisting in discharge planning.

(5) Intake/admissions coordinator. There shall be one staff member designated to perform an Intake/Admissions Coordinator function.

**817.8 Severability.**

If any provision of this Part or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect other provision or applications of this Part which can be given effect without the invalid provision or applications, and to this end the provisions of this Part are declared to be severable.

**817.9 Savings and renewal clause**

Any operating certificate issued by the Office prior to the promulgation of this Part for the operation of a program subject to regulations of the former Part 818 shall remain in effect until the term of such operating certificate has been renewed or such operating certificate is suspended or revoked through process of law, at which time any recertification of such program or renewal of such operating certificate shall be pursuant to the provisions of this Part.