



Department  
of Health

Office for  
the Aging

# Social Adult Day Care/ Social Adult Day Services (SADC/SADS)

## Person Centered Service Plan (PCSP) Template for SADC/SADS Usage

### Background

The New York State (NYS) Department of Health (DOH) and the New York State Office for the Aging (NYSOFA) are jointly issuing the following person centered service plan (PCSP) template and guidance to ensure that all providers are using a consistent approach in the planning of participant services in Social Adult Day settings. The template and guidance apply to DOH's Social Adult Day Care (SADC) services and NYSOFA's Social Adult Day Services (SADS).

### PCSP Template Usage - Details and Information

The Home and Community Based Services (HCBS) Settings Final Rule ([HCBS Final Rule](#)) requires service planning for participants in Medicaid HCBS programs to be developed through a person centered planning process that addresses health and long-term services and support needs in a manner that reflects individual preferences and goals. The HCBS Final Rule establishes the minimum requirements for person centered service plans (PCSPs) that are developed through this process. The template is intended to guide the development of PCSPs to be compliant with the HCBS Final Rule and NYSOFA's SADS regulations that were adopted pursuant to Section 215 of New York State Elder Law.

### PCSP Template Updates – SADC/SADS Personalization

The template is intended to assist SADC/SADS programs in developing PCSPs that reflect the individual's strengths and preferences and include individually identified goals and desired outcomes. At minimum, the SADC/SADS program must:

- Add the SADC/SADS site name and physical address at the top of the template, and
- Add the SADC/SADS site logo to the top left of the site name and address, if applicable

*Note: Template sections and table columns should not be removed/deleted. Rows may be added for additional information, as needed. This information is needed to ensure compliance with the HCBS Final Rule.*

### **Tips for Completing the SADC/SADS PCSP Template**

- It is recommended to keep the template in Word when completing so that responses can be typed, and fields can adjust and resize as needed.
- Use the participant's completed assessments, including the functional assessment completed prior to admission, the COMPASS assessment, and/or the comprehensive PCSP provided by the Managed Long Term Care (MLTC) Plan. Use the information in these assessments to complete the information fields in the template, including the health information section.
- Conduct the person centered planning process by following the flow of the template. It was created to be completed from top to bottom.
  - For example, the preferences and goals identified early in the template will help make it easier to identify community activities that the participant may be interested in.
- When completing the "SADC/SADS Activities" section, please be sure to review the current, complete list of activities the SADC/SADS offers for participants.
  - As a reminder, all SADC/SADS are required to offer activities in the following categories, per 9 NYCRR Part 6654.20:
    - Cultural
    - Educational
    - Intellectual
    - Physical Group Activities
    - Social
- Please be sure when updating the PCSP below to ALWAYS re-ask every question and discuss every topic. Do not assume the situation has not changed.

***Reminder: Per 9 NYCRR Part 6654.20, the participant's PCSP must be completed within 30-days of their admission to the SADC/SADS program and at least annually thereafter. Additionally, the PCSP must be updated when the participant's needs or condition change or at the request of the participant.***

**SADC/SADS Name**

SADC/SADS Address

# Person Centered Service Plan

## PCSP Completion Information

<b>Person Completing PCSP (Name):</b> Click or tap here to enter text.
<b>Date of PCSP Completion:</b> Click or tap to enter a date.
<b>Authorization Period End Date (12 months from date PCSP completed):</b> Click or tap to enter a date.

## SADC/SADS Participant Information

<b>Name:</b> Click or tap here to enter text.	<b>Date of Birth:</b> Click or tap to enter a date.
<b>Address:</b> Click or tap here to enter text.	
<b>Does the participant live alone?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>If no, indicate who participant lives with and their relationship to the participant:</b> Click or tap here to enter text.	
<b>Phone:</b> Click or tap here to enter text.	<b>Email:</b> Click or tap here to enter text.
<b>Preferred Language:</b> Click or tap here to enter text.	
<b>Gender:</b> Click or tap here to enter text.	<b>Gender Identity:</b> Click or tap here to enter text.

<b>Insurance Co./MLTC Plan:</b> Click or tap here to enter text.
<b>Insurance/Medicaid ID:</b> Click or tap here to enter text.

Insurance/MLTC Plan Primary Care Manager	
<b>Name:</b> Click or tap here to enter text.	
<b>Phone:</b> Click or tap here to enter text.	<b>Email:</b> Click or tap here to enter text.

Secondary / Back-Up Care Manager	
<b>Name:</b> Click or tap here to enter text.	
<b>Phone:</b> Click or tap here to enter text.	<b>Email:</b> Click or tap here to enter text.

Primary Care Physician	
<b>Name:</b> Click or tap here to enter text.	
<b>Phone:</b> Click or tap here to enter text.	<b>Email:</b> Click or tap here to enter text.

Schedule
<b>Days of SADC/SADS Attendance:</b> <input type="checkbox"/> Sun <input type="checkbox"/> Mon <input type="checkbox"/> Tue <input type="checkbox"/> Wed <input type="checkbox"/> Thu <input type="checkbox"/> Fri <input type="checkbox"/> Sat <b>Time:</b> Click or tap here to enter text.
<b>Method of Transportation to/from SADC/SADS:</b> Click or tap here to enter text.

## Contact Information

Contact 1	
<b>Name:</b> Click or tap here to enter text.	<b>Contact Type:</b> Choose an item.
<b>Relationship to Participant:</b> Click or tap here to enter text.	

## SADC/SADS Name

SADC/SADS Address

Contact 1	
<b>Phone:</b> Click or tap here to enter text.	<b>Email:</b> Click or tap here to enter text.

Contact 2	
<b>Name:</b> Click or tap here to enter text.	<b>Contact Type:</b> Choose an item.
<b>Relationship to Participant:</b> Click or tap here to enter text.	

Contact 3	
<b>Name:</b> Click or tap here to enter text.	<b>Contact Type:</b> Choose an item.
<b>Relationship to Participant:</b> Click or tap here to enter text.	

## Participant Health Information

Pertinent Diagnoses
<i>Utilize the space below to indicate any pertinent diagnoses (for MLTC participants), health issues, or conditions the participant has. This should include physical, cognitive, mental health, and behavioral health conditions.</i>
Click or tap here to enter text.

Medications
<b>Does the participant require assistance with medication while attending the SADC/SADS?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>If yes, what level of assistance is needed?</b> Choose an item.

<i>Utilize the space below to indicate any medications, over the counter, herbal supplements, etc. that the participant is taking and the condition/diagnoses it is being taken for.</i>	
Click or tap here to enter text.	Click or tap here to enter text.
Click or tap here to enter text.	Click or tap here to enter text.
Click or tap here to enter text.	Click or tap here to enter text.
Click or tap here to enter text.	Click or tap here to enter text.
Click or tap here to enter text.	Click or tap here to enter text.

Other Health Information
<i>Utilize the space below to indicate any other health information as listed.</i>
<b>Allergies (including allergies to medication and food, severity, and required emergency response):</b> Click or tap here to enter text.
<b>Dietary Restrictions/Requirements (include reason/justification):</b> Click or tap here to enter text.
<b>Nutrition (Preferences/Special Diet):</b> Click or tap here to enter text.

## SADC/SADS Name

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### Capacity for Independence

Is the participant able to communicate their needs? (ex. pain, hunger) Yes No

If no, please describe why the participant is unable to do so:

Click or tap here to enter text.

Does the participant appear able to make their own decisions? Yes No

If no, please describe why the participant is unable to do so:

Click or tap here to enter text.

Can the participant be left alone and unsupervised? Yes No

If no, please describe why the participant is unable to do so, including any cognitive or communication needs:

Click or tap here to enter text.

Does the participant have any pain and/or sensory needs? (ex. sensitivity to temperatures or noises, inability to recognize the need for toileting) Yes No

If yes, describe what the needs are, and what assistance is to be provided:

Click or tap here to enter text.

### Functional Assessment / Staff Intervention

*For each of the activities of daily living (ADLs) please indicate the level of care the participant requires from SADC/SADS staff and if the participant has any assistive technology/device (e.g., cane for mobility or continence pads). Also, at the bottom, please indicate if there is a preference on who provides personal care assistance to the participant.*

ADL	Level of Care	Assistive Technology/Device
Mobility	Choose an item.	Click or tap here to enter text.
Transfers	Choose an item.	Click or tap here to enter text.
Toileting	Choose an item.	Click or tap here to enter text.
Continence	Choose an item.	Click or tap here to enter text.
Eating	Choose an item.	Click or tap here to enter text.
Medication Self-Administration	Choose an item.	Click or tap here to enter text.
Supervision/Monitoring	Choose an item.	Click or tap here to enter text.

**Personal Care Assistance Preference:** Choose an item.

### Risk Management and Safeguards

*Identify any risks to the participant's health/wellbeing, potential trigger(s), previous responses to triggers, measures in place to minimize risks, and safeguards. Safeguards detail the support needed to keep the participant safe from harm and actions to be taken when their health and welfare is at risk. (Note: Add more copies of the table if needed.)*

<b>Risk</b>	Click or tap here to enter text.
<b>Trigger(s)</b>	Click or tap here to enter text.

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<b>Known Response(s)</b>	Click or tap here to enter text.
<b>Measure(s) in Place</b>	Click or tap here to enter text.
<b>Safeguard(s)</b>	Click or tap here to enter text.

## Preferences and Strengths/Needs

Preferences	
<i>Ask the participant about the things they enjoy, like, and dislike. Utilize the space below to indicate their responses, along with any other known preferences they have, including preferences related to receiving the SADC/SADS services.</i>	
Click or tap here to enter text.	

Strengths & Needs	
<i>Ask the participant about the things they are good at, or feel is a need. Utilize the space below to indicate their responses, along with any other known strengths or needs they have.</i>	
Click or tap here to enter text.	

## Goals & Activities

Goals	
<i>Use the space below to identify the participant's chosen health care and social goals and desired outcomes. This may include psychosocial needs, spiritual, and cultural needs, etc. Goals may be long-term or short-term and should have measurable outcomes. Be sure to include the outcome criteria, action and/or steps to achieve or work towards the goal, and where applicable, indicate which activity(s) the goal is tied to. Include strategies to achieve desired outcomes. (Note: Add more copies of the table if needed.)</i>	

<b>Goal</b>	Click or tap here to enter text.
<b>Outcome Criteria</b>	Click or tap here to enter text.
<b>Actions and/or Steps</b>	Click or tap here to enter text.
<b>Related Activity(s)</b>	Click or tap here to enter text.

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<b>Outcome Criteria</b>	Click or tap here to enter text.
<b>Actions and/or Steps</b>	Click or tap here to enter text.
<b>Related Activity(s)</b>	Click or tap here to enter text.

SADC/SADS Activities	
<i>Use the space below to identify SADC/SADS activities the participant is interested in and any supports or modifications they may need to be able to participate in the activity. For example, a participant in a wheelchair or someone who has difficulty standing, may need to do a modified version of yoga (maybe from a chair or wheelchair), or someone who is visually impaired may need extra-large BINGO cards or a magnifier. (Note: Add more rows as needed.)</i>	
<b>SADC/SADS Activity</b>	<b>Needed Supports (if interested)</b>
Click or tap here to enter text.	Click or tap here to enter text.
Click or tap here to enter text.	Click or tap here to enter text.
Click or tap here to enter text.	Click or tap here to enter text.

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### Community Activities

Utilize the space below to identify any community events and activities the participant is interested in attending. List the details of what the activity is, where it occurs, and any supports needed for them to attend the activity, including coordination needed/completed, etc. At a minimum SADCs/SADS are responsible for helping to coordinate community integration activities for the participant. (Note: Add more copies of the table if needed.)

*Tip: To help the participant identify community events and activities they may be interested in, review the participant's goals and preferences. For example, someone who wants to read more may be interested in joining a book club at the local library, or a virtual one. A participant who wants to spend more time with family may want to setup a monthly lunch meeting with a family member they do not often see.*

<b>Community Activity</b>	Click or tap here to enter text.
<b>Details</b>	Click or tap here to enter text.
<b>Supports Needed</b>	Click or tap here to enter text.

<b>Community Activity</b>	Click or tap here to enter text.
<b>Details</b>	Click or tap here to enter text.
<b>Supports Needed</b>	Click or tap here to enter text.

### Work/Volunteer Interests

Please speak to the participant about their interests in obtaining/keeping a job and/or volunteering and document their interests below.

**Is the participant interested in working or volunteering (or already doing so)?**

Yes – Work Only    Yes – Volunteer Only    Yes – Work & Volunteer  
 No    N/A – Participant is unable to do so.

**If N/A – Participant is unable to do so, please describe why the participant is unable to work or volunteer:**

Click or tap here to enter text.

**If yes, please describe what work and/or volunteer opportunity the participant is interested in pursuing, including details on frequency, days/time, etc.:**

Click or tap here to enter text.

**If yes, please describe what support is being provided so the participant is able to achieve their goal of working and/or volunteering (ex. assistance with application, transportation to work/volunteer or interview, etc.):**

Click or tap here to enter text.

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### Modifications to Participant Rights

HCBS Final Rule Rights		
<p>Use the space below to identify if there is a modification to the participant's rights. If there is, please provide justification and details for the modification(s).</p> <p>Details must include the following: diagnosis/condition related to the modification, positive interventions and supports used before this modification, method for collection and review of data for effectiveness, timeframes/limits for review and determination of need for modification, and assurance that the modification will cause no harm.</p>		
Participant Rights	Modification Needed?	Justification & Details
Having access to food at any time.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Click or tap here to enter text.
Freedom and support to control their own schedules and activities.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Click or tap here to enter text.
Freedom to have visitors of the choosing at any time.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Click or tap here to enter text.

Other Participant Rights		
<p>Use the space below to identify if there is a modification to any participant's rights not captured under the HCBS Final Rule section above. If there is, please be sure to document the participant right(s) being modified and provide the justification(s) and details for the modification(s).</p> <p>Details must include the following: diagnosis/condition related to the modification, positive interventions and supports used before this modification, method for collection and review of data for effectiveness, timeframes/limits for review and determination of need for modification, and assurance that the modification will cause no harm.</p>		
Participant Rights	Modification Needed?	Justification & Details
Click or tap here to enter text.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Click or tap here to enter text.
Click or tap here to enter text.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Click or tap here to enter text.

### PCSP Acknowledgement

Acknowledgement
<p>I agree with what is written in this person centered service plan and acknowledge that I, the participant, lead the person centered planning process. I understand my rights and/or I have someone I trust who can help me with them. This includes the right to integrate with and be a part of my community, separate from the Social Adult Day Care and Social Adult Day Services I am choosing to receive. I acknowledge that I was offered options to integrate with and be part of my community, and my decisions on goals or activities related to this are documented in this plan. I understand that my plan will be reviewed regularly, that I can ask for it to be reviewed sooner, and whom to speak to about having my plan reviewed and updated. I agree to this plan being shared with the people that need it to provide my services.</p>

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<b>Acknowledgement</b>	
<b>Participant or Designated Representative Signature:</b>	<b>Date:</b> Click or tap to enter a date.