HCBS rules and regulations for SADC programs

HCBS rules and regulations for SADC programs, with focus on developing comprehensive SADC person-centered service plans, ensuring community integration, enhancing participant rights, and training staff for HCBS compliance.

NYSADSA

New York State Adult Day Services Association Inc.

Contact:

518-867-8839

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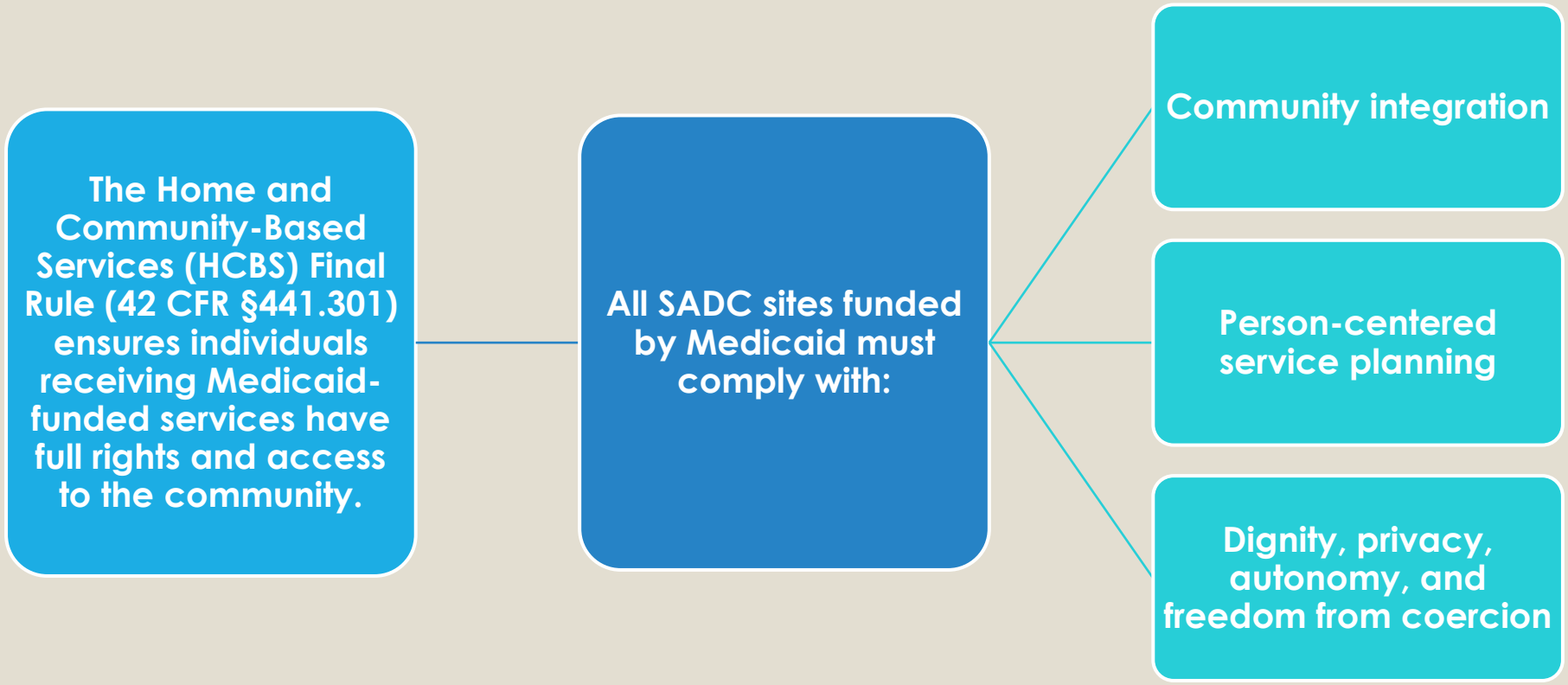
nysadultday.org

Overview of HCBS Final Rule



The HCBS Final Rule requires all Home and Community Based Settings meet the following requirements:

Setting ensures individuals have the freedom and support to control their schedules and activities; and have access to food at any time.

Setting ensures individuals can have visitors of their choosing at any time.

Setting is physically accessible to the individual.

PERSON CENTERED CARE PLANNING

Requirements

Reframing Challenges – Overcoming Barriers

Sometimes, we hear concerns like,

‘Person-centered planning takes too much time.’

Instead of seeing it as ‘extra work,’ let’s view it as ‘a way to make care easier in the long run.’

Rather than thinking ‘participants don’t know what they want,’ think ‘every person communicates preferences in their own way.’

By shifting our perspective, we turn obstacles into opportunities!"

Regulations: 42 CFR 441.301(c)(1)-(3)

PCSP Must:

- Be based on a functional assessment
- Led by the participant and include their chosen circle of support
- Reflect participant's preferences, goals, strengths, and support needs
- Include informed consent and **distribution** to the participant

Common Gaps:

- No documented participant input
- Generic or outdated goals
- Plans not available on-site

Person-Led vs. Process-Led Planning Understanding the Difference:

A PCSP should **start with the person, not the paperwork**. CMS expects plans to demonstrate how the individual is **leading** the planning process—not just participating in it.

Referenced Regulation:

- **42 CFR §441.301(c)(1)** – Requires that planning is "driven by the individual" and reflects their goals, preferences, and choices

Person-Led Planning	Process-Led Planning
The individual guides the discussion and sets the direction of the plan	Staff guide the process based on forms, policies, or pre-set agendas
Reflects the participant's voice, preferences, and vision for their life	Reflects the provider's perspective or system constraints
Uses natural language the participant would use	Uses clinical or programmatic jargon
Planning meetings are flexible, occur in comfortable settings, and involve chosen people	Meetings are scheduled around staff, often rushed, and follow standard checklists
Goals are personal and meaningful to the participant	Goals may be generic or based on "what's available" in the program
Builds on strengths, desires, and life experiences	Focuses on deficits, services, or compliance needs

Writing Effective and Compliant PCSPs

Key Points:

- The PCSP must reflect:
  - The individual's needs, preferences, and goals
  - Led by the participant or their representative
  - Strategies and supports tailored to the individual

Writing Effective and Compliant PCSPs

- Required elements:
  - SMART goals
  - Cultural needs and language preferences
  - Risk assessment and planning for health/safety concerns
- Use NYSDOH NYSOFA standardized template, with required documentation of all planning steps.

How to Support Person-Led Planning

Practical Tips:

- Start with open-ended questions:
- "What brings you joy?" "Who do you like spending time with?"
- Schedule at a time/place chosen by the participant
- Encourage inclusion of family/friends/advocates
- Use the person's language in the PCSP
- Translate, use visuals, or simplify terms to ensure true understanding

During the Meeting:

- Let the participant guide pace and order
- Use the PCSP form only after the conversation has naturally unfolded
- Focus on what's *important to* and *important for* the person
- Ensure the participant signs off on their plan with full understanding

Introduction to the PCSP Template
Developed by NYSDOH and NYSOFA

Introduction to the PCSP Template
Developed by NYSDOH and NYSOFA

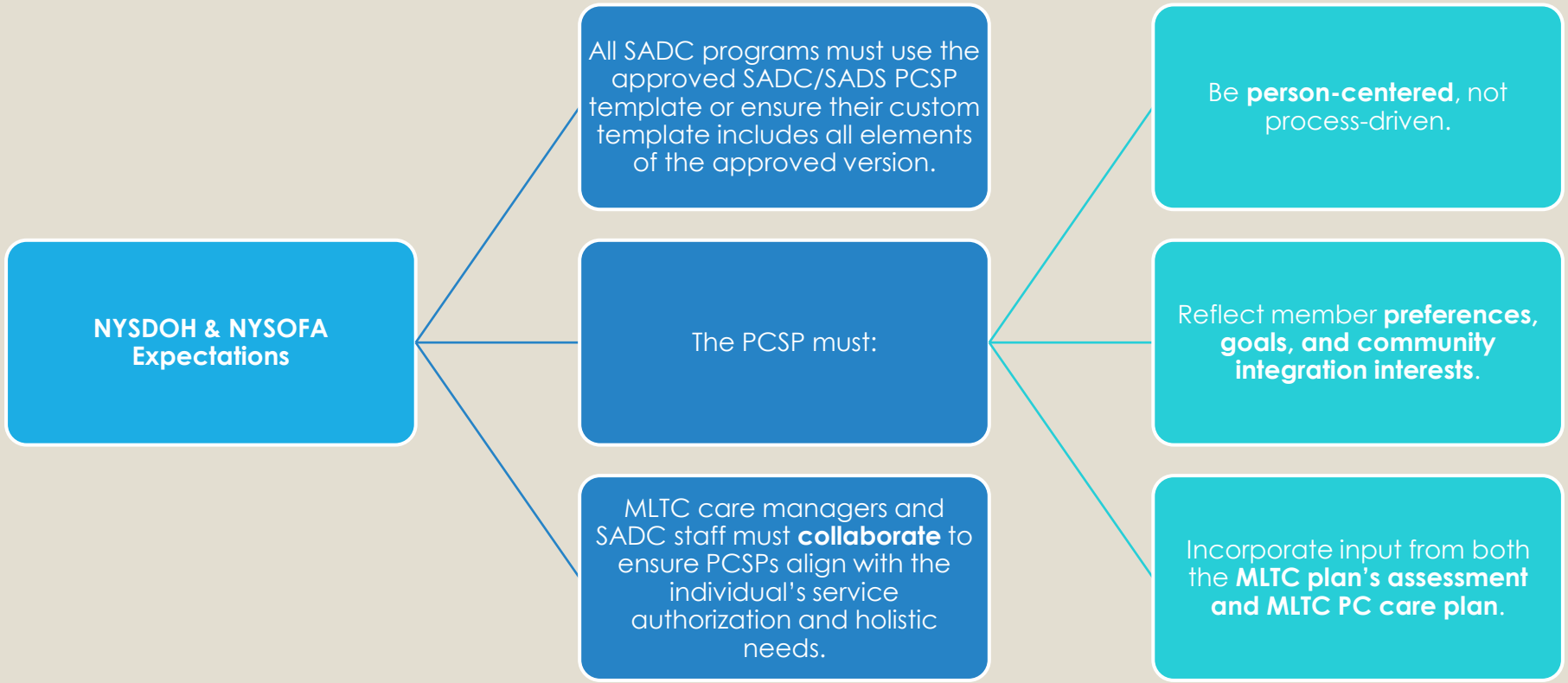
Purpose of the Template:

- Ensure PCSPs reflect **individual preferences, strengths, needs, and goals**
- Meet requirements of **42 CFR §441.301(c)** and **9 CRR-NY 6654.20**
- Support HCBS Final Rule compliance

Template Overview:

- Developed by NYSDOH and NYSOFA
- Mandatory for all SADC programs receiving MLTC referrals
- Must be updated **within 30 days of admission**, **annually**, and **when needs change**

Completing the PCSP Template – NYSDOH / NYSOFA Guidance



Recordkeeping Do's & Don'ts – Avoiding Blank Fields

Why Proper Documentation Matters:

- Required under **9 NYCRR §6654.20** and **HCBS Final Rule 42 CFR §441.301**
- Demonstrates compliance with assessments, planning, and service delivery
- Supports audits, reviews, and internal quality assurance

Best Practices for Documentation:

Complete Every Section of the PCSP and compliance forms

- Each field is **intentional** and linked to regulatory criteria
- Use "N/A" (Not Applicable) when a section truly does not apply
- Use "None at this time" if a participant has no needs in that category

Maintain Updated, Accurate Records

- Keep the **most recent signed version** on file
- Review and revise PCSPs at least **annually** or **when needs change**
- Keep all training logs, attendance sheets, and assessments **for 6 years**

Translate if Needed

- If records are handwritten or in another language, provide **translated and legible copies**

Common Mistakes to Avoid:

❌ Leaving fields blank—CMS and DOH interpret this as missing or incomplete

❌ Using outdated versions of forms

❌ Submitting inconsistent or conflicting information across documents

❌ Relying only on verbal or undocumented staff knowledge

Key Instructions for Template Completion

General Guidelines:

- Complete in **Microsoft Word**; fields are adjustable
- Fill from **top to bottom**; do **not delete any sections**
- Additional rows may be added (see Appendix for instructions)

Participant Engagement:

- The participant (or representative) must be actively involved
- Their **input must guide every section**

Update Policy:

- Revisit **every section** during updates—never assume previous answers are still valid

Section-by-Section Breakdown – Administrative Details

Template Header:

- Include SADC Name, Address, and Logo (optional)

PCSP Completion Information:

- Name of staff completing the plan
- Date of completion
- PCSP authorization period (ends 12 months after completion date)Does not apply to MLTC Authorization means end of PCSP date.

Participant Information:

- Name, DOB, Address, Contact, Gender Identity
- Living situation and preferred language
- Primary and backup MLTC contacts

Health & Risk Documentation

Health Information Section:

Capture **medical diagnoses**, medications, allergies, dietary restrictions

Use MLTC plan and assessments for accuracy

Risk Management and Safeguards:

Document any risks (e.g., fall risk, behavioral concerns)

Describe **specific supports or monitoring** strategies

This section ties into **participant rights** and safety

Strengths, Preferences, and Goals

Preferences and Strengths/Needs:

Reflect what is important **to** and **for** the participant

Use language from the participant, not general statements

Goals and Activities:

Use **SMART goals** (Specific, Measurable, Achievable, Relevant, Time-bound)

Link goals to SADC/community activities

Include frequency, responsible staff, and any needed supports

Rights and Acknowledgement

Modifications to Rights (if any):

- Must be **documented**, include **assessed need**, and **justification**
- Only permitted when absolutely necessary, never for staff convenience
- **Review MLTC care plan for Risk assessments and modifications.**

PCSP Acknowledgement:

- Signed by the participant or representative
- Confirms they led/participated in planning, understood their choices, and agree with the plan
  - **Retention:** Keep all PCSPs **on file and accessible** for monitoring and auditing

WHAT IS A SMART GOAL ?

WHAT IS A SMART GOAL ?

Take a moment to recall a time when you felt truly heard and understood—maybe by a friend, a colleague, or a family member.

How did that make you feel?

The heart of Person-Centered Care

Now, imagine if every person in our care experienced that same feeling every day.

That's the heart of Person-Centered Care Planning.

Lets explore how SMART goals help us achieve that while enhancing compliance and quality of care.

Understanding SMART Goals

To provide person-centered care, we use SMART goals. SMART stands for

Specific,

Measurable,

Achievable,

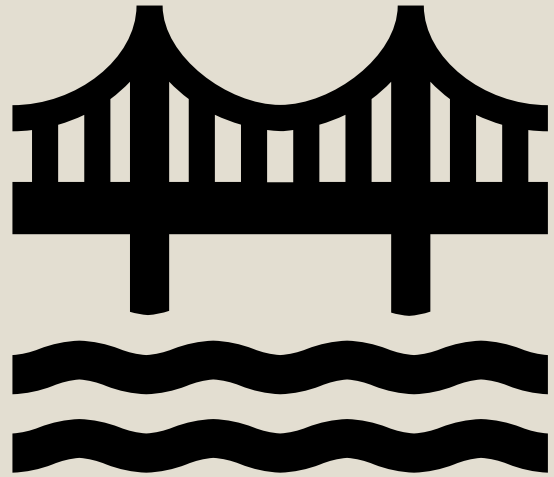
Relevant,

Time-bound.

Let's explore each element in a way that sticks.

I want you to visualize a bridge—each SMART element is a step that gets us across to success.

If a step is missing, we can't reach our goal



Conversation with the Participant :

🎯 🗣️ *"I miss being able to move around on my own without having to rely on others."*

❤️ 🗣️ *"I'd love to feel more steady on my feet, even if it's just a little at a time."*

🧍 🗣️ *"I don't want to be stuck sitting all the time—I want to do something active that feels safe for me."*

Before SMART Goals:

Maria's original goal in her care plan was:
🚫 *"Maria will improve her mobility."*

🔷 **Problem:** This goal is **too vague**—there's no clear way to measure success or know when it's achieved.

SMART Goal Implementation:

After a person-centered discussion with Maria, staff developed a **SMART goal** tailored to her needs:

✅ **Specific: Maria will use a walker to walk 50 feet with minimal staff assistance.**
✅ **Measurable: Success will be tracked by her ability to complete the 50-foot walk at least three times per week.**
✅ **Achievable: Based on her physical condition, this was realistic with support from staff and gradual progression.**
✅ **Relevant: Maria wants to regain her ability to move independently and participate in activities.**
✅ **Time-Bound: She will achieve this goal within three months and review progress monthly.**

SMART Goal:

"Maria will walk 50 feet with her walker and minimal staff assistance three times a week for three months to improve mobility and confidence in moving independently."

Goal	Maria will walk 50 feet with her walker and minimal staff assistance three times a week for three months to improve mobility and confidence in moving independently.
Outcome Criteria	Maria successfully walks 50 feet with her walker and minimal staff assistance at least three times per week for three consecutive months.
Actions and/or Steps	- Encourage Maria to participate in guided walking sessions with staff support. - Provide verbal cues and encouragement to build confidence. - Monitor and document progress weekly to ensure gradual improvement. - Adjust assistance levels as needed based on Maria's endurance and balance.
Related Activity(s)	Supervised Walking Program, Fall Prevention Exercises, Strength & Balance Training

Results At end of PCSP Period :

🌟 **Increased Confidence:** Maria became **more confident** in walking short distances and started joining social activities more often.
🌟 **Better Physical Strength:** She gradually increased her endurance, making it easier to move around safely.
🌟 **Reduced Fall Risk:** By **practicing balance techniques**, she reported **fewer instances of feeling unsteady**.
🌟 **Greater Social Engagement:** Feeling more independent, she **joined a seated dance class** and engaged in group discussions without hesitation.

Why This Worked:

✅ **Clear direction**—Maria and staff knew exactly what was expected.

✅ **Motivation & accountability**—She saw **measurable progress**, which encouraged her to continue.

✅ **Flexibility & adjustments**—After three months, she was **able to walk 50 feet**, so the goal was **updated** to support further improvement.

COMMUNITY INTEGRATION

Community Integration

Community Integration

Regulatory Basis:

- 42 CFR 441.301(c)(4)(i)

Key Elements:

- Individualized activities aligned with PCSP goals
- Engagements with the broader community (not just internal or SADC-only events)
- Transportation and support to facilitate inclusion
- **Not Community Integration:**
- In-house events, staff-led group trips with no public interaction, errands or routine appointments

What the Department Expects for Community Integration in SADC Programs

Regulatory Reference:

42 CFR §441.301(c)(4)(i): Settings must support full access to the **greater community**.

Applies to all SADC sites contracted with MLTC plans.

Core Expectations from the Department:

Individualized Community Access

- Activities must be based on the **participant's PCSP goals**, interests, and preferences
- Community outings should reflect meaningful engagement, not just group supervision

Meaningful Integration

- Participants should (have the opportunities if they choose) interact with people **not receiving Medicaid HCBS**
- Integration goes beyond **presence**—it involves participation and contribution in real community settings

Core Expectations from the Department:

Opportunities for Employment & Volunteering

If a participant expresses interest in working or volunteering, this should be reflected in the PCSP and followed up with appropriate supports

Simply attending a provider-run day program does **not** meet this expectation

Use of Public Settings

Examples: libraries, community centers, cultural events, grocery stores, cafes, fitness centers

DOH emphasizes use of **non-disability-specific** venues

Documentation Must Show:

- Clear connection between PCSP goals and community outings
- Frequency, types of activities, and participant input
- Support provided (e.g., transportation, staff escort)
- Any limitations must be documented and justified

Not Considered Community Integration:

Only participating in in-house activities

Visiting other SADC or HCBS programs only

Group activities with no public interaction (e.g., "field trip" to a park with no engagement)

Trips driven by provider routine rather than participant choice (e.g., weekly supermarket runs)

📌 **CMS Observation from Site Visits (2022–2023):**

"Providers often confuse off-site activities with community integration, even when participants are not engaged with the broader public."
— CMS Heightened Scrutiny Review Findings

Community Integration Standards

Supporting Member Participation in the Community

Key Points:

- Community integration means:
  - Activities that connect members with the broader community—not just group outings with staff
  - Member choice in how they spend their day and with whom

Community Integration Standards

Supporting Member Participation in the Community

- SADCs must:
  - **Offer** individualized integration opportunities aligned with the PCSP
  - Assist with arranging transportation, if needed
  - **Document offers, member responses, and supports provided**
- Examples of compliance:
  - A member choosing to attend a library program alone
  - Coordination with family for religious service attendance

DOH Expectations for Transportation and Staff Support

The Department of Health emphasizes that Social Adult Day Care (SADC) programs **must support full community access** in accordance with **42 CFR §441.301(c)(4)(i)**. This includes providing, coordinating, or facilitating transportation and, where needed, staff support during community integration activities. Specific requirements include:

- **Providing information** about and coordinating transportation for members.
- **Helping members prepare** for activities (e.g., registration, attire, reminders).
- **Arranging for support persons** (guardian, aide, etc.) if a member cannot attend alone.
- **Assisting with transitions** (e.g., from SADC to community activity).
  - While SADCs **are not required** to transport members or accompany them, they **are expected to coordinate**these supports when necessary to help members engage in person-centered, goal-oriented community activities.

Required Documentation in the PCSP Template

SADC PCSPs must include:

- Details on how each community activity will be accessed.
- What coordination or supports the SADC is offering (e.g., transportation, escort, financial planning).
- Whether the member is able or unable to attend independently—and if not, who will assist them.
  - For example, if a member wishes to volunteer at a library but cannot attend alone, the SADC must document if they will help arrange transport or coordinate with a caregiver to attend.

Required Documentation in the PCSP Template

SADC sites **must not restrict** members from engaging in community activities during program hours.

Staff or support must be **available as needed** to ensure inclusion—particularly for members with physical, cognitive, or safety-related limitations.

- These supports must be **clearly documented** in the PCSP, and alternatives must be considered if the member declines an option.

Crisis Planning & Cultural Humility in the PCSP

Crisis Planning in the PCSP

Crisis Planning in the PCSP

Definition:
Crisis planning identifies **what constitutes a crisis for the participant**, how to **prevent crises**, and what to do **during and after one occurs**. It is essential for **preserving the person's autonomy, safety, and well-being**.

Crisis Planning in the PCSP
Key Elements to Document:

- **What triggers a crisis** for the individual (e.g., sudden changes, health events, emotional distress).
- **Signs that a crisis is emerging** (e.g., behavior changes, confusion).
- **Who should be contacted** and in what order (e.g., family, MLTC care manager, 911).
- **Preferred interventions** or supports to use before, during, or after a crisis (e.g., calming activities, a quiet room).
- **Steps to restore stability** and support recovery.

Why It Matters:

- Demonstrates proactive support and risk management.
- Aligns with HCBS Final Rule requirements for health and safety.
- Helps ensure appropriate, person-preferred responses are used.

Cultural Humility in the PCSP

- **Definition**:
  Cultural humility is the ongoing process of self-reflection and learning that providers use to **understand and honor a person's cultural background, values, beliefs, and practices**.

Cultural Humility in the PCSP How to Reflect in the PCSP:

- **Ask and document** the participant's preferences regarding:
  - Language
  - Religion or spirituality
  - Food, customs, and holidays
  - Gender roles or provider preferences
  - Family involvement in care planning
- **Avoid assumptions**—let the person define what matters to them culturally.
- **Involve cultural representatives** or translation services if needed.

Why It Matters:

- Builds trust, engagement, and accuracy in care planning.
- Promotes equity, dignity, and personalized care.
- Required under **Title VI of the Civil Rights Act** and integrated into CMS HCBS standards.

Crisis Planning & Cultural Humility in the PCSP

Adapting the PCSP to Reflect Real-Life Needs

Key Points:

PCSP in Crisis:

- If a member is hospitalized or relocated, the PCSP must be updated
- Use temporary goals to support recovery or transitional needs

Adapting the PCSP to Reflect Real-Life Needs

Cultural Humility:

Acknowledge language, faith, dietary, and social preferences

Staff must listen and adapt care to lived experiences

Use inclusive planning tools like communication charts or cultural profiles

Documentation:

Record all adjustments, preferences, and offers made

Note who provided input and how decisions were reached

ROLES IN PCSP DEVELOPMENT

Roles in PCSP Development – Care Manager vs. Provider Source: CMS – 42 CFR §441.301(c)(2)

MLTC Care Manager
Responsible for developing the MLTC Person-Centered Service Plan (PCSP), independently of service provision.

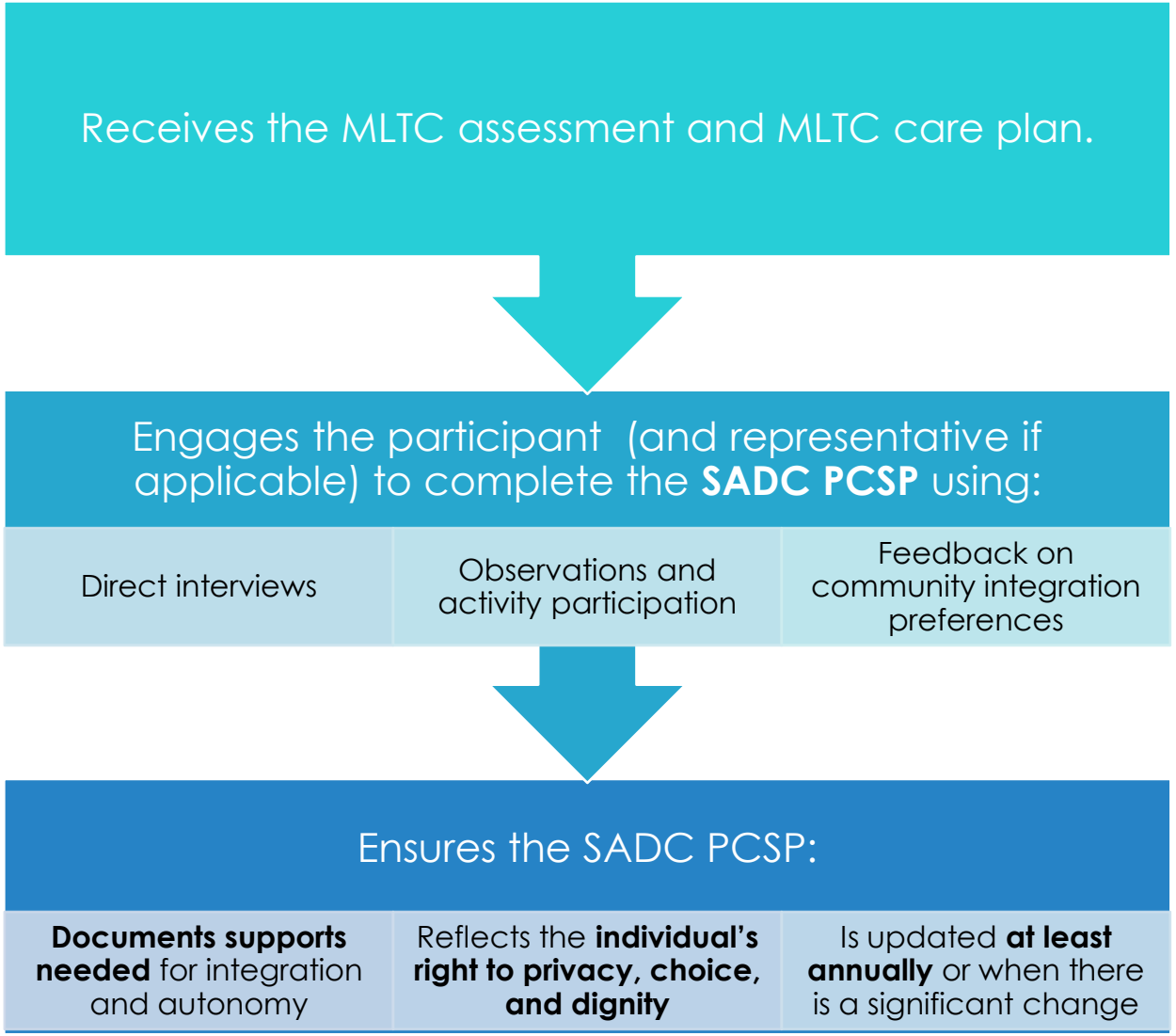
- Leads and facilitates the MLTC planning meeting
- Ensures the participant (and representatives) are active in MLTC plan development
- Documents informed choice regarding services, providers, and settings
- Offers alternatives for supports, activities, and community access
- Coordinates services and monitors implementation
- Revises the plan as needs or preferences change

MLTC Policy 13:11 Plans must consider the individual needs of each enrollee during the assessment process and must clearly identify the need for social day care as a service in the (MLTC) plan of care.

Provider (e.g., SADC Program Staff):

- *Implements the MLTC PCSP and ensures SADC activities align with the plan.*
- Delivers SADC services in accordance with the individual's PCSP
- Encourages choice and supports autonomy in services and routines
- Supports access to the community and integrated activities
- Refers to the care manager if needs, goals, or preferences shift
- Keeps records of service delivery that reflect the PCSP objectives
- Both the care manager and provider play distinct yet essential roles in realizing this balance.

The Role of the SADC Provider



CMS Found Common themes :

https://www.medicaid.gov/medicaid/home-community-based-services/downloads/themes-identified-during-cms.pdf

Individuals are functioning under provider-specific plans of care; in some cases there are plans only known to the case manager and the individual

What This Means

This refers to situations where:

- The **provider (e.g., SADC)** is using its own internal plan that is **not aligned with the (MLTC) person-centered planning process**, or
- The **MLTC care manager develops a plan** (or makes significant decisions) that are **not shared with the provider**, **not documented in the PCSP**, or worse, **not known by the individual's support team**.
  - In essence, it points to a breakdown in **team-based planning** and a failure to honor the individual's **right to transparency, choice, and control**.

Why This Is Non-Compliant

Under the **CMS HCBS Settings Final Rule**:

The MLTC **Person-Centered Service Plan (PCSP)** must be:

- **Shared among all relevant parties**, including the individual and the provider.
- **Transparent**, inclusive of all supports, risks, and goals.
- **Developed collaboratively** with full input from the individual and those chosen by them.

Hidden or unilateral care plans contradict this model, leading to:

- Inconsistent service delivery
- Potential **loss of autonomy** for the participant
- Failed compliance during reviews

Key SADC PCSP Completion Tips

- **Use plain, person-centered language** that reflects the member's voice.
- Don’t copy from the MLTC care plan—**interpret and expand** on it.
- **Include supports** for community goals, even if not currently utilized.
- Document **declinations** of services or activities and offer alternatives.
- Always **list staff or informal supports** responsible for follow-through.

Key PCSP Completion Tips

- The PCSP must reflect the **participant's unique needs, preferences, and strengths**.
- While the MLTC assessments and care plan **inform** the SADC PCSP, the SADC team is responsible for **interpreting** that information and **expanding** it into individualized goals, supports, and activities that reflect the person's participation in the SADC setting.
- The guide stresses that **"preferences and goals identified early help inform subsequent sections"**, and the plan must reflect what is **important to and for the participant**, not just what is noted clinically or functionally by the MLTC plan.

Key PCSP Completion Tips

- **MLTC care plans serve as a foundation** but not the final content for the SADC PCSP.
- **Person-centered planning** requires direct engagement with the participant to document unique goals and preferences specific to the SADC experience.
- SADC providers must use their own assessments and direct interviews to **interpret and tailor** information meaningfully.

STAFF TRAINING REQUIREMENTS PCSP IMPLEMENTATION

Staff Training Requirements

Staff Training Requirements for HCBS & PCSP Implementation

Regulatory Foundation:

- **42 CFR §441.301(c)**: Staff must support person-centered service delivery in accordance with the PCSP.
- NYSDOH and NYSOFA mandate ongoing training as part of HCBS compliance.

🔷 **Core Training Expectations from the Department:**

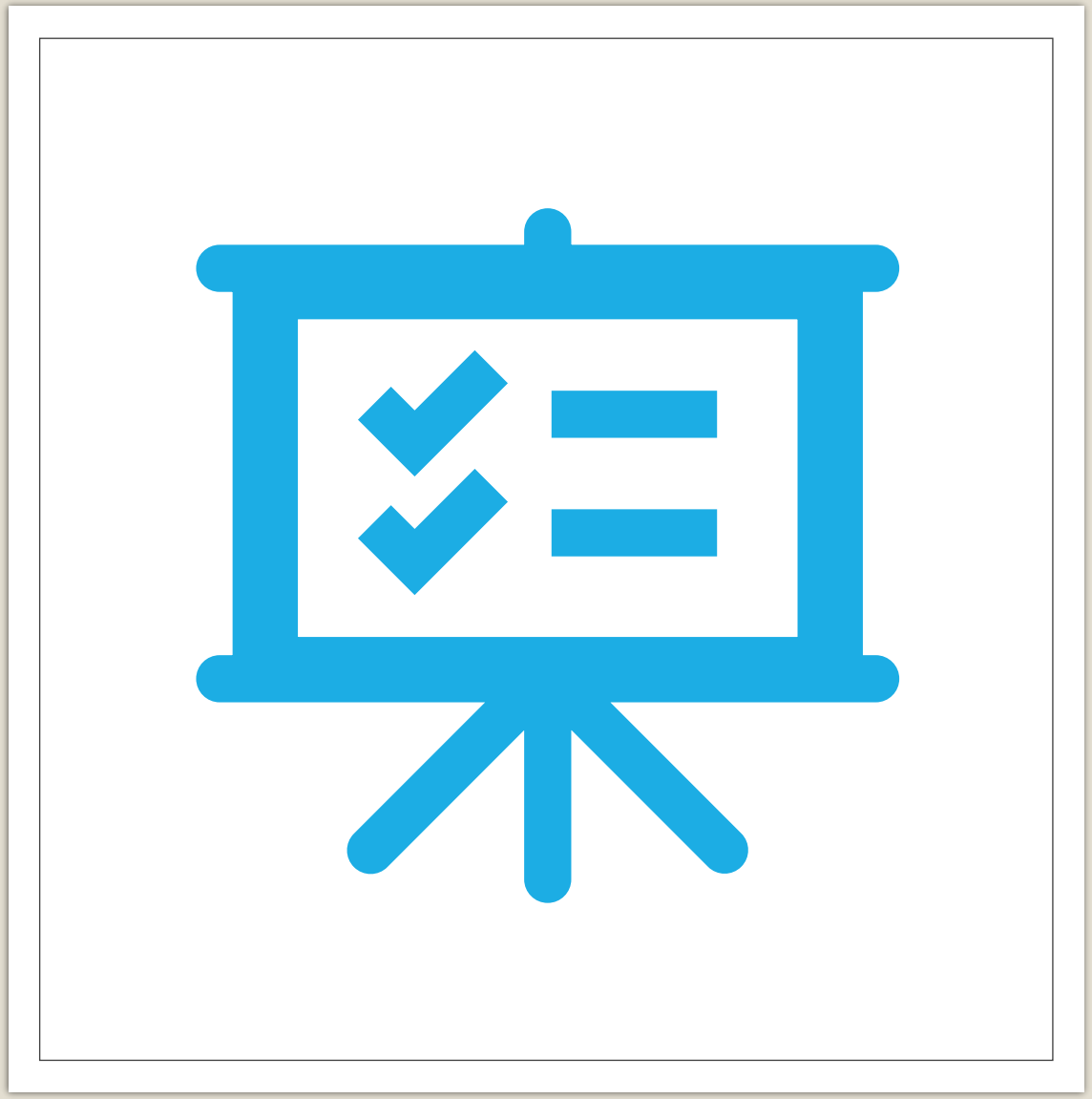
1. **Staff Training Plan Must Include:**
    1. How to **complete the PCSP Template** accurately and thoroughly
    2. How to **support participants' needs, activities, and goals** as outlined in their PCSP
    3. Documentation practices: ensuring staff actions align with PCSP goals
    4. Annual refreshers and competency checks

Compliance Reviews and Remediation

Responding to DOH HCBS Site Reviews

Key Points:

- Annual HCBS compliance reviews are mandatory
- MLTC plans and SADCs must:
  - Review questions prior to site visit
  - Ensure documentation is current and translated (if needed)
  - Participate in the review and respond to any requests



Responding to DOH HCBS Site Reviews

- If non-compliance is found:
  - Submit a **Remediation Plan** using the DOH template
  - Complete all action items within 30 days
  - Provide **Proof of Remediation** (photos, updated policies, etc.)

Wrap-Up & Key Takeaways

What We Covered Today:

- **HCBS Final Rule expectations** for Social Adult Day Care (SADC) settings
- How to develop and document a **person-led, SMART goal-driven PCSP**
- What counts as **true community integration** vs. provider-centered routines
- Importance of **participant rights, informed choice**, and individualized supports
- **Staff training requirements** and maintaining a robust training log
- Best practices for **documentation, recordkeeping**, and compliance reviews

DOH SADC HCBS Compliance Website:

New York State Social Adult Day Care (SADC) Home and Community Based Services (HCBS) Compliance

Practical Considerations for PCSP Creation with Clients Affected by Dementia

Audrey Swanson, LMSW
Executive Director, New York Memory Center
May 16, 2025

About Me

- Executive Director at New York Memory Center
  - Dementia-focused SADC/SADS in Park Slope, Brooklyn, NYC since 1983
  - 36 registered clients as of today; daily census of 12-18 clients
  - More than a decade of experience in social adult day programs and working with people affected by dementia
- HCBS Final Rule Experience
  - Four NYSDOH site audits from 2022 to 2025
  - Complete overhaul of two agencies' policies/procedures for HCBS final rule
- Person Centered Care Planning Experience
  - Developed more than 50 person-centered care plans (PCSP's)
  - Yes - I have been remediated too!

Challenges to PCSP Creation Caused by Dementia

HCBS Final Rule Standard

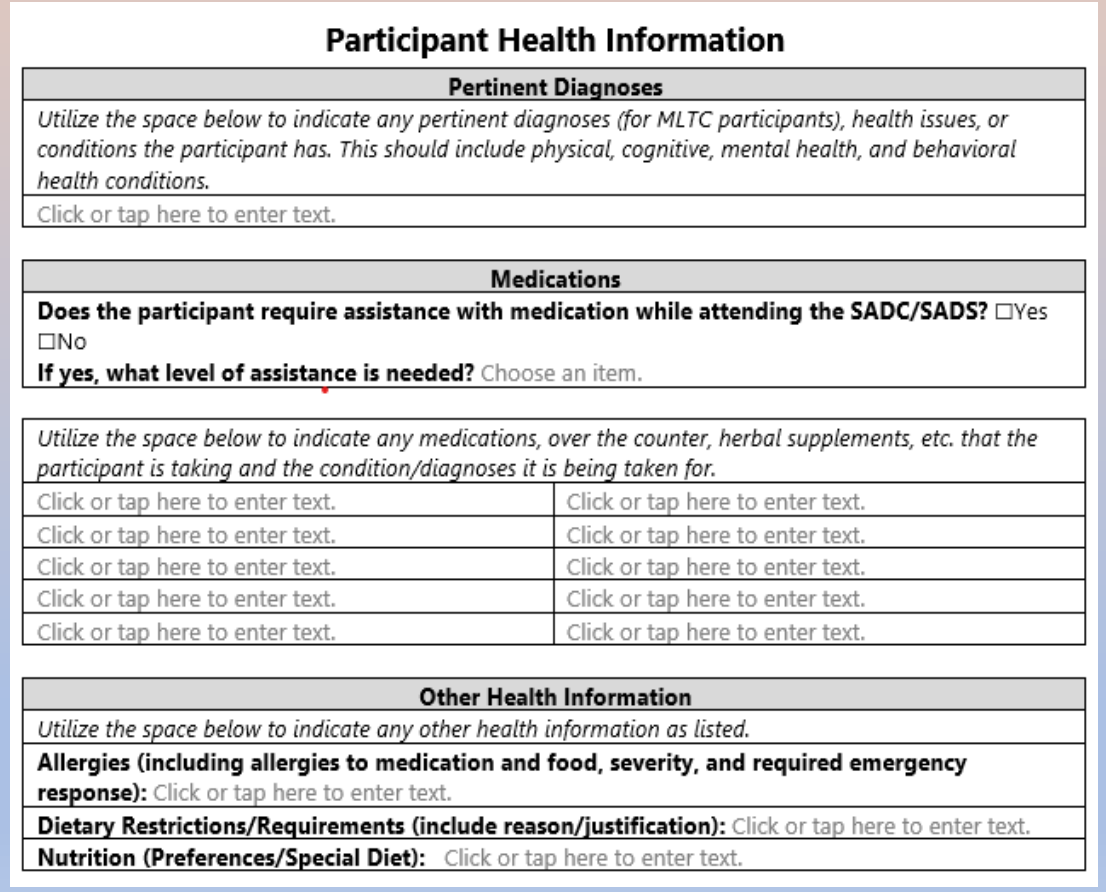
- Client drives the PCSP
- Client says strengths/preferences
- Goal-directed behavior/SMART goals
- Community integration
- Employment and volunteering

Dementia Concern

- Decision-making ability impaired
- Expressive and receptive aphasia
- Executive brain function impaired
- Wandering and confusion
- Medical issues such as falls, not using an assistive device, etc.

What can we do now?

Section: Participant Health Information



Participant Health Information

Pertinent Diagnoses
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.
Click or tap here to enter text.

Medications
Does the participant require assistance with medication while attending the SADC/SADS? ☐Yes ☐No **If yes, what level of assistance is needed?** Choose an item.

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

- Include <u>all</u> of the specific challenges your client has from any assessments. For example:
  - Known dementia diagnosis
  - Expressive or receptive aphasia
  - History of unsafe wandering or other behavioral disturbances
  - Others?
- These are useful later when identifying potential **risks** and justifying any **modifications** to HCBS final rule rights.

Section: Level of Care

Level of Care

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.

- Each area in the Level of Care section is relevant to everything that comes later in the PCSP:
  - Communication and language are highly impacted by dementia
  - Decision making capacity and insight are highly impacted by dementia
  - People with dementia may wander and experience confusion, or neglect their care needs without supervision

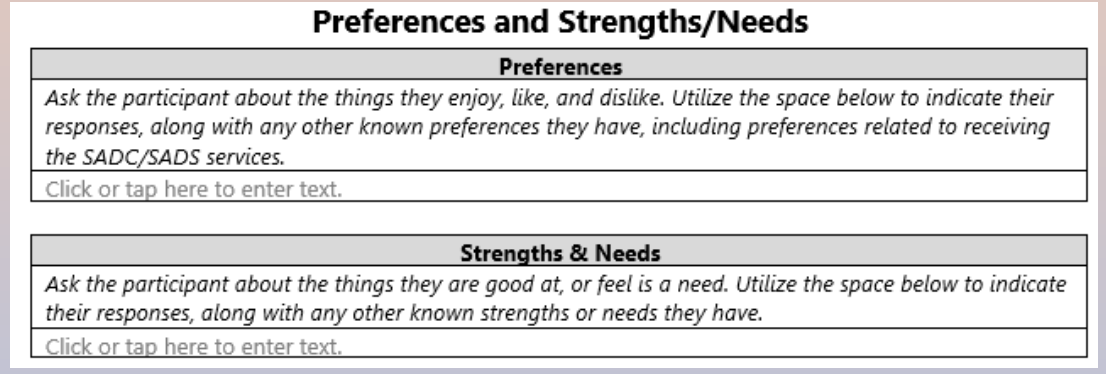
Section: Risk Management and Safeguards

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.	
Risk	Click or tap here to enter text.
Trigger(s)	Click or tap here to enter text.
Known Response(s)	Click or tap here to enter text.
Measure(s) in Place	Click or tap here to enter text.
Safeguard(s)	Click or tap here to enter text.

- This is one of the most <u>critical</u> areas in the PCSP for high-risk clients like those with dementia. You will refer to these risks in the *Goals and Activities*, *Community Integration*, *Employment*, and *Modifications to HCBS Rights*.
- Risks may include:
  - Falling
  - Wandering
  - Behavioral disturbance
  - Others?

Section: Preferences and Strengths/Needs



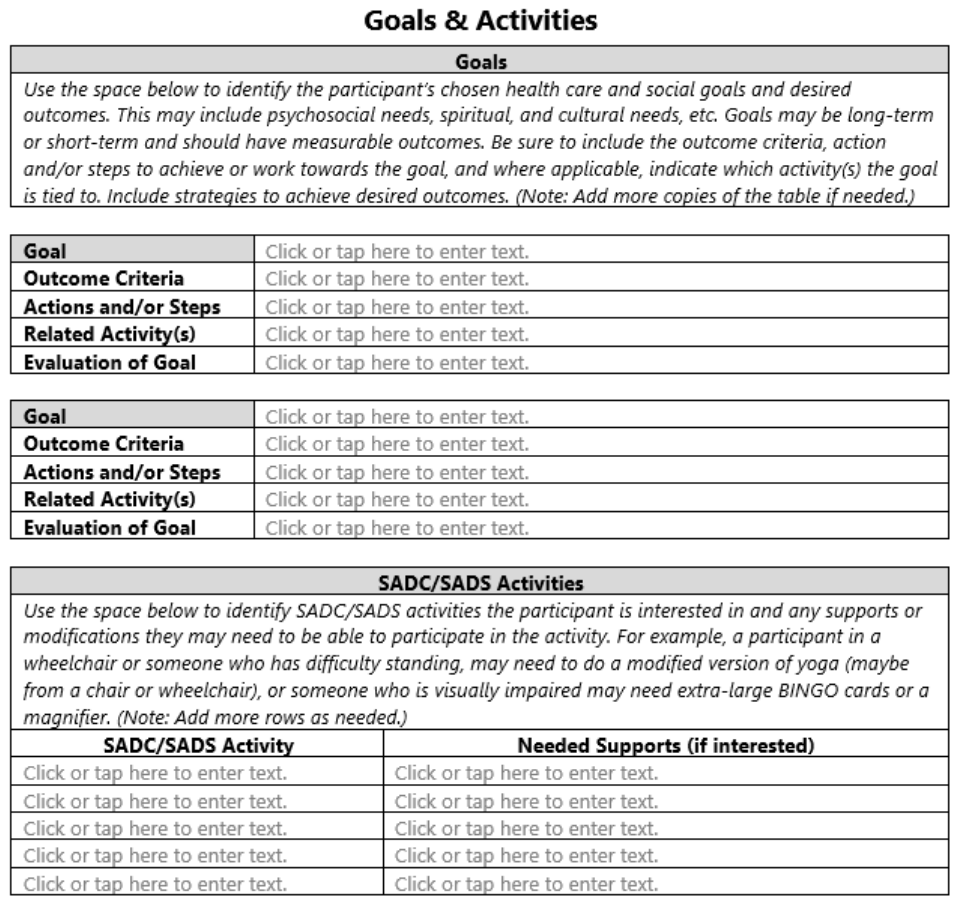
Preferences and Strengths/Needs

Preferences
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.
Click or tap here to enter text.

Strengths & Needs
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.
Click or tap here to enter text.

- Clients with **aphasia** may struggle to respond. *What now?*
- Even late in dementia, clients still have the ability to express a **choice** especially to a “yes/no” question.
- This helps clients share what they like and prefer. You can try *non-verbal* approaches like pictures.
- You may state that you asked the client to share, and say why they could not. In this case, you should include information known by staff.

Section: Goals and Activities



Goals & Activities

Goals
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.)

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

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

SADC/SADS Activities	
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.)	
SADC/SADS Activity	**Needed Supports (if interested)**
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.

- Because dementia affects goal-directed behavior and decision-making capacity, goal-setting will be challenging. *What now?*
- In SADS/SADC, key program goals may include **psychosocial** factors: isolation, loneliness, boredom, depression, anxiety.
- Relief from these feelings *is* a reasonable approach to developing a goal.

Example: SMART Goals and Psychosocial Factors

- **Goal:** More friends, socialization, things to do / less bored, lonely, depressed, anxious: **specific**, **achievable**, and **relevant**
- **Outcome**: Client will feel less/more _____ by self-report and pre/post test **measures** on Lubben Scale (social isolation), PHQ-9 (depression), DJGLS (loneliness), BPS (boredom), and GAD-7 (anxiety)
- **Actions/Steps**: Client will attend SADS/SADC up to X times per week for socialization / stimulation / relief from _____: **specific**, **measurable**, and **achievable**
- **Related Activities**: List the specific SADS/SADC activities the client enjoys: social, recreational, physical, cognitive, creative, and occupational
- **Evaluation**: Key step to ensure the goal is **time-bound** (added to PCSP)

Section: Community Engagement/Integration

Community Engagement

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.

Community Activity	Click or tap here to enter text.
Details	Click or tap here to enter text.
Supports Needed	Click or tap here to enter text.

Community Activity	Click or tap here to enter text.
Details	Click or tap here to enter text.
Supports Needed	Click or tap here to enter text.

Community Activity	Click or tap here to enter text.
Details	Click or tap here to enter text.
Supports Needed	Click or tap here to enter text.

- Dementia can greatly limit the safe and appropriate community activities for a client.
- Independent activities without structure or supervision may not be possible. *What now?*
- Viable options to suggest:
  - Visiting with family and friends
  - Attending synagogue or church
  - Museums (access programs)
  - Others?
- Supports needed include the needs and risks identified elsewhere.

Section: Employment and Volunteering

Employment and Volunteering

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.

- My experience has shown that when many clients in the age group commonly affected by dementia (older adults) will respond to this in two ways:
  - "I'm retired"
  - "I don't work anymore because…"
- Both responses are appropriate and should be shared in the first box of this section. The "unable to do so" response may also be true, but requires justification.

Section: Modifications to Participant Rights

Modifications to Participant Rights

HCBS Final Rule Rights		
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). 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.		
Participant Rights	**Modification Needed?**	**Justification & Details**
Having access to food at any time.	☐Yes ☐No	Click or tap here to enter text.
Freedom and support to control their own schedules and activities.	☐Yes ☐No	Click or tap here to enter text.
Freedom to have visitors of the choosing at any time.	☐Yes ☐No	Click or tap here to enter text.
Other Participant Rights		
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). 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.		
Participant Rights	**Modification Needed?**	**Justification & Details**
Click or tap here to enter text.	☐Yes ☐No	Click or tap here to enter text.
Click or tap here to enter text.	☐Yes ☐No	Click or tap here to enter text.

- The PCSP tool and HCBS final rule have a way to indicate why some clients cannot exercise their rights under HCBS final rule – notably, **community integration**.
- This is relevant to clients' right to "freedom to control their own schedule and activities."
- Refer to the *Level of Care* and *Risk Management* sections for justifications and modifications.

Questions?

- **Feel free to reach out!**
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  - 718.790.1941 (mobile)
  - https://nymemorycenter.org
  - Linked In

The more you do something, the easier it becomes!