# **New Jersey Department of Human Services**

## **Division of Aging Services**

**Provider Application Section III: Services**

**SOCIAL ADULT DAY CARE**

***Read carefully the description of services and requirements.***

***If you do not qualify, please do not apply.***

**Definition:**

Social adult day care is a community-based group program designed to meet the needs of adults with functional impairments through an individual plan of care. It is a structured, comprehensive program that provides a variety of health, social, and related support services in a protective setting during any part of a day but less than 24 hour care.

Individuals who participate in social adult day care attend on a planned basis during specified hours. Social adult day care assists its participants to remain in the community, enabling families and other caregivers to continue caring at home for a family member with impairment. Social adult day care is a community-based group program designed to meet the needs of adults with functional impairments through an individual plan of care. It is a structured, comprehensive program that provides a variety of health, social, and related support services in a protective setting during any part of a day but less than 24 hour care.

**Service Limitations/Exclusions Include:**

* Limit of three (3) days per week, per Individual Service Agreement (ISA).
* Cannot be combined with Adult Day Health.

# **Billing Codes:**

***JACC*** ***Service/ Unit Rates Per Unit***

J1235 (for TME) 1 day $31.12

J9853 (for NT) 1 day $31.12

**SOCIAL ADULT DAY CARE PROVIDER QUALIFICATIONS**

The applicant must submit evidence that it meets **all** items within the following section(s).

Please check off **ONE** section in which you are applying

Section 1 Section 2 Section 3

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| **Section 1** |

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| 1.a |  | Valid Medicaid provider number for Social Adult Day Care Services |
| 1.b |  | Medicaid Provider # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1.c |  | Submit documented evidence that standards of Attachment 409B-1 are met |
| 1.d |  | Evidence of Liability Insurance and Worker’s Compensation Coverage |

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| **Section 2** |

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| 2.a |  | Submit documented evidence that standards of Attachment 409B-1 are met |
| 2.b |  | Evidence of a formal agreement with a government entity to provide this service |
| 2.c |  | Evidence of Liability Insurance and Worker’s Compensation Coverage |

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| **Section 3** |

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| 3.a |  | Submit documented evidence that standards of Attachment 409B-1 are met |
| 3.b |  | Business entity with evidence of authority to conduct such business in NJ, i.e. NJ Tax Certificate, Trade Name Registration and/or Ownership proof |
| 3.c |  | Evidence of Liability Insurance and Worker’s Compensation Coverage |

**Check all evidence submitted with application.**

Incomplete applications and / or applications submitted without required

documentation and evidence will be returned.

**CERTIFICATION**

For the purpose of establishing eligibility to receive direct payment for services to recipients under the New Jersey JACC Program, I certify that the information furnished on this application is true, accurate, and complete. I am aware that if any of the statements made by me in this application are willfully false, I am subject to punishment, including but not limited to disqualification from the New Jersey JACC Program. I agree to notify the new Jersey Department of Human Services, Division of Aging Services of any changes in the information contained in this application.

Name and Title of Applicant Representative\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_

**ATTACHMENT 409B-1: SOCIAL DAY EVALUATION CRITERIA**

**Submit evidence that you comply with all the following program components:**

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| **Facility** | | |
| 1.a | License or occupancy permit available |
| 1.b | Police and fire department responses agreements |
| 1.c | Safety and emergency management policies and procedures written |

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| **Personnel** | | |
| 2.a | Program director designated |
| 2.b | Adequate staff to meet program needs of target population |
| 2.c | At minimum, nurse consultant identified |

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| **Client Population** | | |
| 3.a | Criteria for target population established based on resources and program abilities of facility (ages, client capacity) |

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| **Program Activities** | | |
| 4.a | Planned and ongoing age appropriate activities based on social, physical, and cognitive needs of the target population (provide an activity calendar) |

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| **Individualized Plans of Care** | | |
| 5.a | Plans of care based on identified individual client needs, jointly developed with clients and family |

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| **Social Services** | | |
| 6.a | Coordination with, and referrals to, available social service community agencies or Social Worker on staff who will periodically have contact with families |

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| **Nutrition (provide a menu)** | | |
| 7.a | A minimum of one nutritionally balanced meal per day provided |
| 7.b | Special diet needs met |
| 7.c | Snacks provided as necessary |

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| **Health Management** | | |
| 8.a | Initial health profile completed |
| 8.a | Monthly weights taken and other health related observations recorded as necessary |

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| **Personal Care** | | |
| 9.a | Personal assistance as needed with mobility and ADLs |

**NOTE: Failure to submit evidence for all components of the application**

**will result in disqualification.**