MACOMB COUNTY COMMUNITY MENTAL HEALTH - FOCUS
CERTIFICATE OF NEED

Name: **Case #:** **Case:**

Date of Birth **Home Phone** **Current Admission**

Address **Primary Program:**
Case Holder:

Index

1. Certificate Of Need: ER Basic Information

Proposed Admit Date ☐ Post-Notification/Appeal

Use Current Date

Consumer Registered at ER
Date **Time**

Use Current Date

Consumer Medically Cleared / Detoxed
Date **Time**

Use Current Date

Hospital Psychiatric Evaluation Start Date

Use Current Date

Hospital Psychiatric Evaluation Start Time

Requesting Hospital Name

Face-to-Face Assessment Completed By lookup

Entered By lookup

Contact Phone #

Level of Care Request

- ☐ Psychiatric Community Inpatient Admission
- ☐ Partial Hospitalization Program
- ☐ Sub Acute
- ☐ Other:
- ☐ Diversion

- ○ Voluntary Admission
- ○ Involuntary Admission
- ☐ NGRI

Picture ID

○ Yes ○ No

What are the possible barriers to prevent a diversion?

characters left: 1024

Consumer Information

Last Name **First Name** **MI**

Address

County of Residence

Home Phone ( ) - x

Primary Phone
- ○ Home
- ○ Cell
- ○ Alternate
- ○ None

Cell Phone ( ) - x

Alternate Phone ( ) - x

City **State** **Zip** lookup

Email

Date of Birth **SSN**

Place Of Birth (city and state if born in the USA, city and country if born in a foreign country)

MI Child ID # lookup

Medicaid ID # lookup

Aliases and Other Identifying Information that can be used to search for a consumer

characters left: 256

Group Home/Residential Facility lookup clear

Gender

- Male
- Female

COFR

Insurance Information

- Adult Benefit Waiver
- Commercial Insurance/HMO Name / #
- Blue Cross / Blue Shield
- QHP
- Medicaid
- Medicaid Children's Waiver
- Medicare #:
- MI Child Program
- SDA, SSI, SSDI
- VA
- None
- Other

Other Ins Name/#:

Save and Continue to ER Medical Information | Save | CANCEL

Back | Home

Name: **Case #:** **Case:**

Date of Birth **Home Phone** **Current Admission**

Address **Primary Program:**
Case Holder:

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2. Certificate Of Need: ER Medical Information

Legal Guardian

○ No Guardianship in Place ○ Parent(s) of Minor Child ○ Court Appointed Guardian

Parent(s) of Minor Child Authorized to Consent to Treatment Clear Information

Mother Clear Information

○ Biological Mother ○ Adoptive Mother

First Name **Last Name**

☐ **Check if address is same as consumer - provide address if not the same**

Address **Home Phone** **Primary Phone**

○ Home
○ Cell
○ Alternate
○ None

Cell Phone

City **State** **Zip** lookup

Alternate Phone

☐ Not a US Address

Email

Father Clear Information

○ Biological Father ○ Adoptive Father

First Name **Last Name**

☐ **Check if address is same as consumer - provide address if not the same**

Address **Home Phone** **Primary Phone**

○ Home
○ Cell
○ Alternate
○ None

Cell Phone

City **State** **Zip** lookup

Alternate Phone

☐ Not a US Address

Email

Divorce Information Clear Information

If Parents are Divorced, Indicate Child Custody Status

Legal Custody: ○ Sole-Mother ○ Sole-Father ○ Joint ○ Unknown

Physical Custody: ○ Sole-Mother ○ Sole-Father ○ Joint ○ Unknown

Copy of Divorce Papers Scanned into FOCUS?

○ Yes ○ No ○ See Hybrid (Paper) Record

Additional Information Related to Parent Consent

characters left: 1024

Court Appointed Guardian Clear Information

First Name **Last Name**

Check if address is Same as Consumer

Address

City State Zip lookup

MI

Not a US Address

Home Phone

Cell Phone

Alternate Phone

Primary Phone

Home
Cell
Alternate
None

Email

Type of Guardianship

Plenary of Person
Plenary of Estate
Plenary of Person and Estate
Guardian Ad Litem
DHS Ward - Permanent
DHS Ward - Temporary
Partial Describe Powers:

Guardian's Relationship to Consumer

Mother
Father
Child
Spouse
Sibling
Public Guardian
Unrelated
Other

Date of Court Order

Expiration Date

Copy of Guardianship Papers Scanned into FOCUS?

Yes No See Hybrid (Paper) Record

Co-Guardian Information

Clear Information

First Name

Last Name

Check if address is Same as Consumer

Address

City State Zip lookup

MI

Not a US Address

Home Phone

Cell Phone

Alternate Phone

Primary Phone

Home
Cell
Alternate
None

Email

Type of Guardianship

Plenary of Person
Plenary of Estate
Plenary of Person and Estate
Guardian Ad Litem
DHS Ward - Permanent
DHS Ward - Temporary
Partial Describe Powers:

Guardian's Relationship to Consumer

Mother
Father
Child
Spouse
Sibling
Public Guardian
Unrelated
Other

Date of Court Order

Expiration Date

Copy of Guardianship Papers Scanned into FOCUS?

Yes No See Hybrid (Paper) Record

Standby Guardian Information

Clear Information

First Name

Last Name

Check if address is Same as Consumer

Address

Home Phone

Primary Phone

- Home
- Cell
- Alternate
- None

Cell Phone

Alternate Phone

City **State** **Zip** lookup

MI

Not a US Address

Email

Type of Guardianship

- Plenary of Person
- Plenary of Estate
- Plenary of Person and Estate
- Guardian Ad Litem
- DHS Ward - Permanent
- DHS Ward - Temporary
- Partial Describe Powers:

Guardian's Relationship to Consumer

- Mother
- Father
- Child
- Spouse
- Sibling
- Public Guardian
- Unrelated
- Other

Date of Court Order

Expiration Date

Copy of Guardianship Papers Scanned into FOCUS?

- Yes
- No
- See Hybrid (Paper) Record

Additional Guardianship Information

characters left: 1024

Other Medications

	Medication	Medication Type	Dates	Prescribing Physician Info

Add new other medications for the client below.

Medication lookup clear Edit name (if not found)

Medication: Dosage: Qty:

Medication Type

Dates

Start: End:

Instructions

Reason

Prescribing Physician

Prescribing Physician Type

Medication lookup clear Edit name (if not found)

Medication: Dosage: Qty:

Medication Type

Dates

Start: End:

Instructions

Reason

Prescribing Physician

Prescribing Physician Type

Medication lookup clear Edit name (if not found)

Medication: Dosage: Qty:

Medication Type

Dates
Start: End:

Instructions

Reason

Prescribing Physician

Prescribing Physician Type

Medication lookup clear Edit name (if not found)

Medication: Dosage: Qty:

Medication Type

Dates
Start: End:

Instructions

Reason

Prescribing Physician

Prescribing Physician Type

Add More Medications

Medical issues that need immediate medical attention

Yes No

If yes, explain

characters left: 1024

Prescribed Medications

Medication	Dates	Prescribed By	Qty Prescribed

✓Spell Check

Record Added **Record Changed**

Save and Continue to ER Substance Use | Save | CANCEL

Back | Home

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Date of Birth **Home Phone** **Current Admission**

Address **Primary Program:**
Case Holder:

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9. Demographics
10. Complete Medical Information
11. Send Copy to
12. Evidence of Substance Abuse
13. Disposition

3. Certificate Of Need: ER Substance Use

Current Substance Abuse? ○ Yes ○ No

History of Substance Abuse? ○ Yes ○ No

Blood/Alcohol Test ○ Yes ○ No

Urine Screen ○ Yes ○ No

What, if any, substances used in the last 72 hours?

characters left: 1024

If Alcohol, Binges ○ Yes ○ No

Continuous Use ○ Yes ○ No

✓Spell Check

Record Added **Record Changed**

Save and Continue to ER Reason for Referral / Risk Assessment

Save CANCEL

Back Home

Name: **Case #:** **Case:**

Date of Birth **Home Phone** **Current Admission**

Address **Primary Program:**
Case Holder:

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4. Certificate Of Need: ER Reason for Referral / Risk Assessment

Precipitating Event

Events/situations that lead up to the consumer coming to the hospital for services. Ask: What happened to bring you in TODAY, NOW? Why did you attempt suicide, what prompted you to take the OD...? What lead up to coming into the hospital for help/tx today [vs. yesterday/last week etc]?

characters left: 2048

Key Issues

401 Criteria should be documented here including a description of current risk assessment: if the consumer can contract for safety (in a treatment facility vs. in the community). Ideation, plan, intent, means and access to means. Include past risk assessment: ideation, plan, intent, means, and outcome (required medical intervention, did not seek medical intervention). The narrative should include sx and behaviors that are being displayed by the consumer currently. The documentation needs to be described in **behavioral terms:** document dates & frequencies of behaviors when possible e.g. has been banging their head against the wall twice a day for the past week; describe what you are documenting by using **AS EVIDENCED BY: AEB** and listing the evidence supporting your description.

characters left: 4096

SUICIDAL

	Present (< 30 days)	Recent (> 30 days - 1 year)	Past (> 1 year)
Ideation / Threat	Yes No	Yes No	Yes No
Attempt	Yes No	Yes No	Yes No

Comments

characters left: 30000

HOMICIDAL

	Present (< 30 days)	Recent (> 30 days - 1 year)	Past (> 1 year)
Ideation / Threat	Yes No	Yes No	Yes No
Intent	Yes No	Yes No	Yes No
Plan	Yes No	Yes No	Yes No
Attempt	Yes No	Yes No	Yes No

Comments

characters left: 30000

✓Spell Check

Record Added **Record Changed**

Save and Continue to ER Diagnosis | Save | CANCEL

Back | Home

Name: **Case #:** **Case:**

Date of Birth **Home Phone** **Current Admission**

Address **Primary Program:**

Case Holder:

Disability Designation:

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13. Disposition

5. Certificate Of Need: ER Diagnosis

AXIS I

	ICD-9	ICD-10	Description	Status Date	Status
Pri				Use Current Date	
Sec				Use Current Date	
Ter				Use Current Date	

Substance Abuse Diagnoses

	ICD-9	ICD-10	Description	Status Date	Status
Pri				Use Current Date	
	Specifier/Status Detail				
Sec				Use Current Date	
	Specifier/Status Detail				
Ter				Use Current Date	
	Specifier/Status Detail				

AXIS II

	ICD-9	ICD-10	Description	Status Date	Status
Pri				Use Current Date	
Sec				Use Current Date	
Ter				Use Current Date	

AXIS III

	ICD-9	ICD-10	Description	Status Date	Status
Pri				Use Current Date	
Sec				Use Current Date	
Ter				Use Current Date	

AXIS IV

- ☐ Economic problems
- ☐ Problem accessing healthcare
- ☐ Educational problems
- ☐ Occupational problems
- ☐ Housing problems
- ☐ Problem with primary support group
- ☐ Problem related to social environment
- ☐ Problem related to interaction with legal system
- ☐ Other psychosocial and environmental problems
- ☐ Behavioral / Personality issues

AXIS V

Current GAF **GAF Date** **Show Functional Assessment Measure History**

Use Current Date

Diagnostic Formulation

characters left: 4096

Additional Information / Help

Co-Occurring Consumer Quadrant

Co-Occurring Consumer Quadrant Comments

characters left: 1024

Diagnosis Made By (Name/Credentials)

Diagnosis Effective Date

Use Current Date

History of Diagnosis lookup

Last Updated

Disability Designation

Developmental Disability

Yes No

Mental Illness

Yes No

SUD

No SUD
Not Evaluated for SUD
1 or more SUD Dx Codes active or in partial remission (use within past year)
1 or more SUD Dx Codes with all SUD Dx codes in full remission (no use for 1 year)
Results from screening suggest SUD

Individual received an assessment only, and was found to meet none of the disabilities listed above

Yes No

✓Spell Check

Record Added **Record Changed**

Save and Continue to ER Clinical Summary | Save | CANCEL

Back Home

PCE Care Management

Name: **Case #:** **Case:**

Date of Birth **Home Phone** **Current Admission**

Address **Primary Program:**
Case Holder:

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6. Certificate Of Need: ER Clinical Summary

Hospital Preliminary Discharge Plan

Type the recommended d/c plan for the consumer when s/he is considered stable. All SA issues, no matter how minor or significant, **MUST** be addressed in each d/c plan. Indicate if the consumer is currently open with a provider.

characters left: 1024

Provider Comments

If a psychiatric bed is not available at the requesting hospital, please indicate below or include other comments.

characters left: 1024

Hospital Psychiatric Evaluation Stop Date

Use Current Date

Hospital Psychiatric Evaluation Stop Time

✓Spell Check

Record Added **Record Changed**

Save and Continue to Complete Basic Information | Save | CANCEL

Back | Home

Name: **Case #:** **Case:**

Date of Birth **Home Phone** **Current Admission**

Address **Primary Program:**
Case Holder:

Index

7. Certificate Of Need: Complete Basic Information

Last Name **First Name** **MI**

Address

County of Residence

City **State** **Zip** lookup

Home Phone ( ) - x

Cell Phone ( ) - x

Alternate Phone ( ) - x

Primary Phone
- Home
- Cell
- Alternate
- None

Email

Residential Living Arrangement

- Unknown
- Living in private residence with natural or adoptive family member(s).
- Living in private residence not owned by CMH/provider, alone or w/spouse or non-relative(s).
- Homeless on the street or in a shelter for the homeless
- Prison/jail/juvenile detention center
- Nursing Care Facility
- Institutional setting (congregate care facility, boarding schools, Child Caring Institutions, state facilities)
- Private residence that is owned by PIHP, CMHSP, or contracted provider
- Foster family home
- Specialized residential home
- General residential home

Number of Beds in Residential or Institutional Setting

1-3 4-6 7-15 16+ Unknown or N/A

Date of Birth **SSN**

Place Of Birth (city and state if born in the USA, city and country if born in a foreign country)

MI Child ID # lookup **Medicaid ID #** lookup

Aliases and Other Identifying Information that can be used to search for a consumer

characters left: 256

Group Home/Residential Facility lookup clear

Gender

Male

Marital Status

Divorced Married

(●) Female

( ) Never Married ( ) Separated

( ) Widowed

Race / Ethnic Origin 1

( ) N/A
( ) White
( ) Black or African American
( ) American Indian or Alaskan Native
( ) Asian
( ) Native Hawaiian or other Pacific Islander
( ) Some other race
( ) Unknown Race
( ) Consumer Refused to Provide Information

Race / Ethnic Origin 2

( ) N/A
( ) White
( ) Black or African American
( ) American Indian or Alaskan Native
( ) Asian
( ) Native Hawaiian or other Pacific Islander
( ) Some other race
( ) Unknown Race
( ) Consumer Refused to Provide Information

Race / Ethnic Origin 3

( ) N/A
( ) White
( ) Black or African American
( ) American Indian or Alaskan Native
( ) Asian
( ) Native Hawaiian or other Pacific Islander
( ) Some other race
( ) Unknown Race
( ) Consumer Refused to Provide Information

Ethnicity / Cultural Identity

Hispanic or Latino / Latina

( ) Yes ( ) No ( ) Unknown

Arab American / Chaldean

( ) Yes ( ) No ( ) Unknown

Primary Spoken Language

Religion

Veteran Status

( ) Yes ( ) No ( ) Unknown

Parental Status (Has child under 18)

( ) Yes ( ) No

Department of Human Services

Child currently served by DHS for abuse and neglect ( ) Yes ( ) No

Child currently served by another DHS program ( ) Yes ( ) No

Child Enrolled in Early On

If consumer is an adult or a child NOT enrolled in Early On, select 'No'

( ) Yes (●) No

Wraparound Service

( ) Yes ( ) No

Contact / Mailing Information

Select the Mail Recipient for this Consumer

( ) Consumer ( ) Guardian ( ) Parent ( ) Spouse ( ) Do not Mail ( ) Other

Accommodations

characters left: 256

✓ Spell Check

Record Added

Record Changed

Name: **Case #:** **Case:**

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8. Certificate Of Need: Contacts

Other Emergency Contact

Clear Information | History

Last Name **First Name**

Phone Number **Primary Phone**
- ○ Home
- ○ Cell
- ○ Alternate
- ○ None

Cell Phone

Alt Phone

Email

Address

Relationship
- ○ Mother ○ Father
- ○ Child ○ Legal Guardian
- ○ Spouse ○ Unrelated
- ○ Sibling
- ○ Other

City **State** **Zip** lookup

☐ Not a US Address

☐ **Check if address is Same as Consumer**

Additional Contact

Clear Information | History

Last Name **First Name**

Phone Number **Primary Phone**
- ○ Home
- ○ Cell
- ○ Alternate
- ○ None

Cell Phone

Alt Phone

Email

Address

Relationship
- ○ Mother ○ Father
- ○ Child ○ Legal Guardian
- ○ Spouse ○ Unrelated
- ○ Sibling
- ○ Other

City **State** **Zip** lookup

☐ Not a US Address

☐ **Check if address is Same as Consumer**

✓ Spell Check

Record Added **Record Changed**

Name: **Case #:** **Case:**

Date of Birth **Home Phone** **Current Admission**

Address **Primary Program:**
Case Holder:

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9. Certificate Of Need: Demographics

Residential Living Arrangement

Number of Beds in Residential or Institutional Setting

○ 1-3 ○ 4-6 ○ 7-15 ○ 16+ ◉ Unknown or N/A

Education

- ○ Unknown / Unreported
- ○ Completed less than high school
- ○ Completed special education, high school, or GED
- ○ In school - Kindergarten through 12th grade
- ○ In training program
- ○ In Special Education
- ○ Attended or is attending undergraduate college
- ○ College graduate

If In Special Ed

- ○ Emotionally Impaired (EI)
- ○ Cognitive Impaired (CI)
- ○ Severely Multiply Impaired (SXI)
- ○ Autistic Impaired (AI)
- ○ Health Impaired (HI)
- ○ Not Applicable

Highest Grade

Employment Status

- ○ Employed full time (30 hours or more per week) competitively
- ○ Employed part time (less than 30 hours per week) in competitively
- ○ Unemployed - looking for work, and/or on layoff from job
- ○ Participates in sheltered workshop or facility-based work
- ○ In unpaid work (e.g. volunteering, internship, community service)
- ○ Self-employed (e.g. micro-enterprise)
- ○ In enclaves/mobile crews, agency-owned transitional employment
- ○ Participates in facility-based activity program where specialty supports and services are provided to assist an individual in achieving non-work related goals
- ○ Not in the competitive labor force – includes homemaker, child, student, retired, resident of an institution, or incarcerated

Earned wage is Minimum Wage or greater

○ Yes ○ No ○ N/A - Person is not working

Financial Information

Total Annual Household Income
(include both taxable & non-taxable for consumer if single, consumer & spouse if married, parent(s) of minor)

Number of Dependents

Corrections Related Status

Past Legal & Current Legal Information

Legal Involvement?

☐ Circuit

Yes No If yes, specify:

District
Juvenile Justice

✓ Spell Check

Record Added **Record Changed**

Save and Continue to Complete Medical Information | Save

CANCEL

Back | Home

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10. Certificate Of Need: Complete Medical Information

Release to Physician Signed?

Yes No **Reason:**

Physicians

Location: Primary Care Physician (PHCP)

Date of Last Visit

Name: lookup

Location: Primary Care Physician (PHCP)

Date of Last Visit

Name: lookup

Add Physician to List

Current Medical Problems

characters left: 512

Consumer Has Advanced Psychiatric Directives?

Yes No

✓Spell Check

Record Added **Record Changed**

Save and Continue to Send Copy to | Save | CANCEL

Back | Home

Name: **Case #:** **Case:**

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11. Certificate Of Need: Send Copy to

Instructions:
Once this document has been signed, it will be copied and sent to all parties listed below. For all documents that are to be sent outside of your agency, please be sure you have a valid Authorization for Release of Information before adding this copy request.
- To notify staff of document completion, click on **Send to Staff**.
- To send a copy of this document to a location outside of your agency, click on **Send External Copy**.

5 Document Copies

Send Copy To / Review By	Status
lookup clear	
lookup clear	
lookup clear	
Location: lookup clear **Contact Name:** **Purpose:**	
Location: lookup clear **Contact Name:** **Purpose:**	

Send to Staff Send External Copy

Record Added **Record Changed**

Save and Continue to Evidence of Substance Abuse | Save

CANCEL

Back Home

Name: **Case #:** **Case:**

Date of Birth **Home Phone** **Current Admission**

Address **Primary Program:**
Case Holder:

12. Certificate Of Need: Evidence of Substance Abuse

Number of prior SA treatments and detail

characters left: 512

Comments and SA Information

Any hx of blackouts or OD? What are the past recovery attempts? Longest period of recovery? What areas of functioning has been imparied b/c the consumer substance use? Any hx of seizures/DTs/hallucinations? Does the consumer want Substance Abuse tx? Does the consumer feel that their substance use is an issue for them?

characters left: 11000

Add Drug to List

Key

Drug of Choice: 1 = First Choice - 10 = Last Choice

Number of Days used in the Last 30 Days: 0 = Not Used; 1-29 = No. of Days; 30 = Daily

Method Of Current Dosing: 1 = Oral; 2 = Smoking; 3 = Snorting; 4 = IV; 5 = Other

Type of Drug and Name	Drug of Choice	Age at First Use	Age at Problematic Use	Init.Rx	1- Heaviest Amount Consumed and when 2- Current Consumption	Date of Last Use	Number of days drug used in last 30 days	Method of Current Dosing	
					1 2				
					1 2				
					1				
					1 2				
					1 2				
					1 2				

Assessment Completed By lookup clear

Assessment Entered By lookup clear

Contact Phone #

✓ Spell Check

Record Added **Record Changed**

Name: **Case #:** **Case:**

Date of Birth **Home Phone** **Current Admission**

Address **Primary Program:**
Case Holder:

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13. Certificate Of Need: Disposition

CON sent to MCCMH Access Center on

Access Staff - Verify the following information:
☐ **SSN Verified** ☐ **Birth Date Verified** ☐ **Address Verified**

 # Of Hold Hours and Time Held

Reason for Hold Hours

Consumer re-admitted within 30 days: ○ Yes ○ No ○ Unknown

Disposition

○ Denial

Narrative / Reason for Denial
(Include recommendations/appointment place/date/time for follow-up care/who will transport home)

characters left: 1024

○ Crisis Resolved - Hospital Withdrew Request

○ Diversion / Alternative Services Plan
- ○ Crisis Residential
- ○ Crisis Stabilization

Narrative
(Include recommendations/appointment place/date/time for follow-up care/who will transport home)

characters left: 1024

○ Admission Plan
- ○ Inpatient Hospitalization
- ○ Partial Hospitalization

Admitting Hospital lookup clear

Specify # of Days (Partial Hospitalization Only)

UR Contact Person

UR Contact Phone

UR Contact Fax

Authorization Start Date

Next Review Date

Admission Date

☐ Check this box if this is a Medicare / Medicaid Hospitalization. This will allow Finance Department to modify authorization to match the actual bill.

Case Manager/Therapist lookup clear

Primary Provider lookup clear

Service Authorization

AUTHORIZATION WILL BE GENERATED WHEN CERTIFICATE OF NEED IS SIGNED

AUTHORIZATION WILL HAVE EFFECTIVE DATE EQUAL TO *AUTHORIZATION START DATE* AND EXPIRATION DATE EQUAL TO *NEXT REVIEW DATE* SPECIFIED ABOVE

Consumer Has Crisis Plan?

○ Yes ○ No

Other CMH/QHP Coordination ○ **Yes** ○ **No**

CMH Name

Time CMH Contacted

CMH Contact Person

CMH Phone

QHP

Time QHP Contacted

QHP Contact Person

QHP Phone

Treatment History

(include current and past treatment, including inpatient admissions)

characters left: 4096

Discharge Plan per MCCMH

characters left: 11000

Notes to Provider

characters left: 2048

Access Evaluation Start Date

Use Current Date

Access Evaluation Start Time

Access Evaluation Stop Date

Use Current Date

Access Evaluation Stop Time

✓Spell Check

Electronic Signatures

Instructions

When the form/document is completed, type in your password and click 'Sign and Save'. By entering your password you are electronically signing this form/document. Your signature represents your acceptance and approval of the records. Once signed, any future changes must be made via the 'Change Signed Document' option.

Staff Signature Required By lookup

Enter your password to sign

Record Added

Record Changed

Save and Finalize | Save and Send to Admitting Hospital for Completion | CANCEL

Back Home