

MACOMB COUNTY COMMUNITY MENTAL HEALTH - FOCUS  
PERSON CENTERED PLAN - FULL VERSION - HEADER

Name:

Case #:

Case:

Date of Birth

Home Phone

Current Admission

Address

Primary Program:  
Case Holder:

PCP Header

PCP Preplanning Date

This Plan was  to Consumer/Guardian on

Record Added

Record Changed

SAVE

CANCEL

Back

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**Name:** \_\_\_\_\_ **Case #:** \_\_\_\_\_ **Case:** \_\_\_\_\_  
**Date of Birth** \_\_\_\_\_ **Home Phone** \_\_\_\_\_ **Current Admission** \_\_\_\_\_  
**Address** \_\_\_\_\_ **Primary Program:** \_\_\_\_\_  
**Case Holder:** \_\_\_\_\_

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**1. PCP Preplanning Note: Note**

**PCP Preplanning Date**

[Use Current Date](#)

**Have you been offered independent facilitation?**

Yes  No

**You have chosen the following person to facilitate your plan**

**You have chosen the following person to write down your plan**

**Projected Meeting Information**

**When would be a convenient time to schedule your planning meeting/first appointment?**

**Date**

 

**Time**

 

**Location**

**Are there specific things you would like to discuss at your planning meeting/first appointment?**

(i.e., dreams, desires, concerns, fears, budget, support services, hobbies, classes, entertainment, clubs, activities)

characters left: 4096



**Do you have health or safety issues you want to address?**

Yes  No

**If Yes, List Issues**

characters left: 2048



**Would you like to develop a Crisis Plan?**

Yes  No

**Do you need extra support / assistance in an event of a natural disaster or emergency event?**

Yes  No

If yes, click [here](#) for the safety checklist

**Is there anything you do NOT want to talk about at your meeting?**

characters left: 4096



**Are there family/friends or others who might/will help you while you are receiving CMH services?**

Yes  No

**If yes, who (family/friends, coworkers, guardian, other professionals/staff)?**

characters left: 2048



**Do you have an advanced directive?**

Yes  No

**If yes, are you willing to provide a copy of this for your record?**

Yes  No  Copy is in the Chart

**If no, would you like more information about advanced directives?**

Yes  No

**Have you been offered information (brochure) about ways that you can control your resources for services which would involve Choice Voucher/Self-Determination?**

Yes  No

**Would you like to pursue a Choice Voucher/Self-Determination Agreement?**

Yes  No

**Is there anyone you would like to invite to your planning meeting/first appointment?**

Yes  No

**I Would Like the Following People to Attend my Plan of Service Meeting**

	Name	Relationship	Who will invite the person?
1	<input type="text"/>	<input type="text"/>	<input type="text"/>
2	<input type="text"/>	<input type="text"/>	<input type="text"/>
3	<input type="text"/>	<input type="text"/>	<input type="text"/>
4	<input type="text"/>	<input type="text"/>	<input type="text"/>
5	<input type="text"/>	<input type="text"/>	<input type="text"/>
6	<input type="text"/>	<input type="text"/>	<input type="text"/>
7	<input type="text"/>	<input type="text"/>	<input type="text"/>
8	<input type="text"/>	<input type="text"/>	<input type="text"/>
9	<input type="text"/>	<input type="text"/>	<input type="text"/>
10	<input type="text"/>	<input type="text"/>	<input type="text"/>
11	<input type="text"/>	<input type="text"/>	<input type="text"/>
12	<input type="text"/>	<input type="text"/>	<input type="text"/>

13	<input type="text"/>	<input type="text"/>	<input type="text"/>
14	<input type="text"/>	<input type="text"/>	<input type="text"/>
15	<input type="text"/>	<input type="text"/>	<input type="text"/>

**Comments**

characters left: 4096



**✓ Spell Check**

Save and Continue to Send Copy to	Save	CANCEL
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3. PCP Preplanning Note: Signatures

**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

[Sign and Save](#)

Record Added

Record Changed

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MACOMB COUNTY COMMUNITY MENTAL HEALTH - FOCUS  
PERSON CENTERED PLAN - FULL VERSION - MEETING

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1. Full PCP: Dates

Date of Meeting

Start Time

 

[Use Current Date](#)

Consumer requests to complete Preplanning and meeting on the same day

Yes  No

Reason for any change in preplanned meeting date, verbal approval, or any other circumstance impacting effective date of this PCP

characters left: 512



Effective Date

[Use Current Date](#)

This Plan Expires on

(Maximum of 1 Year)

Next Review Date

[Use Current Date](#)

Spell Check

Save and Continue to Details

Save

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2. Full PCP: Details

Person/Family Strengths

Include skills, relationships, and assets

characters left: 8000



Abilities

characters left: 15000



Have all risk, health, safety, and community inclusion issues identified in the assessment been addressed in the plan?

Yes  No

If no, please explain

characters left: 15000



Co-Occurring SUD?

Stage of Change (Objectives need to correspond)

Yes 
  No 
  Chooses not to discuss 
  Pre-contemplative 
  Contemplative 
  Preparation 
  Action 
  Maintenance

Other Agencies/Providers Involved

- DHS  School  Foster Care  
 SSA  MRS  Court System  
 Employer  Health Care Provider  
 Other:

Add Natural Support

(List any people that are available at no cost to support the consumer, including family, friends and community members.)

Name	Assistance/Support Provided
------	-----------------------------

If no Natural Supports, explain

characters left: 512





**Describe Person's Current Inclusion In The Community**

(Meaningful day activities including volunteer activities, clubs, sports, hobbies, organizations, spiritual activities, work, activities with friends and/or family, clubhouse, leisure activities, walking, etc.)

characters left: 8000



**Does Person Wish More Inclusion In The Community?**

Yes  No. Consumer is satisfied with their current level of community inclusion

**If Yes, Describe way or methods to increase their inclusion in the community**

characters left: 2048



**Desired Outcome For The Future**

(including dreams, desires & wishes)

characters left: 8000



**✓ Spell Check**

**Record Added**

**Record Changed**

**Save and Continue to Goals** **Save** **CANCEL**

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PCP Goal

Goal Number

Goal

What person needs to accomplish in their own words

characters left: 8000



Effective Date

Target Completion Date

Actual Completion Date

Discontinued Date

Objectives

Objective	Dates	
A	Implementation	
	Target	
B	Implementation	
	Target	
C	Implementation	
	Target	

Intervention / Supports

Describe the type of actions that MCCMH staff, provider staff, natural supports, and consumer are going to take to assist the consumer in moving in the direction of their goal and objective(s)

characters left: 8000



**✓ Spell Check**

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Case Holder:

PCP Goal

Goal Number

2

Goal

What person needs to accomplish in their own words

Empty text area for goal description.

characters left: 8000



Effective Date

Date input field with calendar icon

Target Completion Date

Date input field with calendar icon

Actual Completion Date

Date input field with calendar icon

Discontinued Date

Date input field with calendar icon

Objectives

Objective	Dates	
A	Implementation	
	Target	
B	Implementation	
	Target	
C	Implementation	
	Target	

Intervention / Supports

Describe the type of actions that MCCMH staff, provider staff, natural supports, and consumer are going to take to assist the consumer in moving in the direction of their goal and objective(s)

Empty text area for intervention/supports description.

characters left: 8000



✓ Spell Check

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PCP Goal

Goal Number

3

Goal

What person needs to accomplish in their own words

Empty text area for goal description.

characters left: 8000



Effective Date

Date input field with calendar icon

Target Completion Date

Date input field with calendar icon

Actual Completion Date

Date input field with calendar icon

Discontinued Date

Date input field with calendar icon

Objectives

Objective	Dates	
A	Implementation	
	Target	
B	Implementation	
	Target	
C	Implementation	
	Target	

Intervention / Supports

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characters left: 8000



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PCP Goal

Goal Number

Goal

What person needs to accomplish in their own words

characters left: 8000



Effective Date

Target Completion Date

Actual Completion Date

Discontinued Date

Objectives

Objective	Dates	
A	Implementation	
	Target	
B	Implementation	
	Target	
C	Implementation	
	Target	

Intervention / Supports

Describe the type of actions that MCCMH staff, provider staff, natural supports, and consumer are going to take to assist the consumer in moving in the direction of their goal and objective(s)

characters left: 8000



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4. Full PCP: Barriers

Barriers that might need to be considered

characters left: 8000



Referrals Made

characters left: 2048



The transition plan from current service to a less restrictive service would include the following:

(Describe what needs to be in place for transition to a less restrictive service or for discharge to occur.)

characters left: 2048



✓ Spell Check

Record Added

Record Changed

Save and Continue to Authorizations
Save
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Case Holder:

Authorization

Provider

Consumer

PCP

PCP Eff:

Exp:

Service Package

Authorization Effective Date



Authorization Expiration Date



[Use Current Date](#)

Authorizing Agent Notes

characters left: 512



Provider Notes

characters left: 512



Requested Date

Requested / Added By

Service <input type="button" value="lookup"/> <input type="button" value="clear"/>			Standard Unit Type		
Effective Dates <input type="text"/> - <input type="text"/>	Units Per Period Requested <input type="text"/>	Frequency <input type="text"/>	Total Units Requested <input type="text"/>	<input type="button" value="Calculate"/>	
<a href="#">Related Goals</a>					
Notes <input type="text"/>					
Service <input type="button" value="lookup"/> <input type="button" value="clear"/>			Standard Unit Type		
Effective Dates <input type="text"/> - <input type="text"/>	Units Per Period Requested <input type="text"/>	Frequency <input type="text"/>	Total Units Requested <input type="text"/>	<input type="button" value="Calculate"/>	
<a href="#">Related Goals</a>					
Notes <input type="text"/>					
Service <input type="button" value="lookup"/> <input type="button" value="clear"/>			Standard Unit Type		
Effective Dates <input type="text"/> - <input type="text"/>	Units Per Period Requested <input type="text"/>	Frequency <input type="text"/>	Total Units Requested <input type="text"/>	<input type="button" value="Calculate"/>	
<a href="#">Related Goals</a>					

Notes <input type="text"/>			
Service <input type="button" value="lookup"/> <input type="button" value="clear"/>		Standard Unit Type <input type="text"/>	
Effective Dates <input type="text"/> - <input type="text"/>	Units Per Period Requested <input type="text"/>	Frequency <input type="text"/>	Total Units Requested <input type="text"/> <input type="button" value="Calculate"/>
<a href="#">Related Goals</a>			
Notes <input type="text"/>			
Service <input type="button" value="lookup"/> <input type="button" value="clear"/>		Standard Unit Type <input type="text"/>	
Effective Dates <input type="text"/> - <input type="text"/>	Units Per Period Requested <input type="text"/>	Frequency <input type="text"/>	Total Units Requested <input type="text"/> <input type="button" value="Calculate"/>
<a href="#">Related Goals</a>			
Notes <input type="text"/>			
<a href="#">Add More Detail Lines</a>			

<input type="button" value="TEST REQUEST"/>	<input type="button" value="PROCESS REQUEST"/>	<input type="button" value="SAVE and PEND"/>	<input type="button" value="CANCEL"/>
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<input type="button" value="Back"/>	<input type="button" value="Home"/>
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6. Full PCP: Participation

List All People who have participated or are active in this plan

	Name	Relationship	Present
1			<input type="radio"/> Yes <input type="radio"/> No
2			<input type="radio"/> Yes <input type="radio"/> No
3			<input type="radio"/> Yes <input type="radio"/> No
4			<input type="radio"/> Yes <input type="radio"/> No
5			<input type="radio"/> Yes <input type="radio"/> No
6			<input type="radio"/> Yes <input type="radio"/> No
7			<input type="radio"/> Yes <input type="radio"/> No
8			<input type="radio"/> Yes <input type="radio"/> No
9			<input type="radio"/> Yes <input type="radio"/> No
10			<input type="radio"/> Yes <input type="radio"/> No
11			<input type="radio"/> Yes <input type="radio"/> No
12			<input type="radio"/> Yes <input type="radio"/> No
13			<input type="radio"/> Yes <input type="radio"/> No
14			<input type="radio"/> Yes <input type="radio"/> No
15			<input type="radio"/> Yes <input type="radio"/> No

I am satisfied with the supports and services that have been developed as part of my plan:

Yes  No

During my person-centered planning meeting, I requested services, or an amount of those services, that my case manager/supports coordinator/therapist did not include in my service plan.

Yes  No

If yes, the services(s) in the amount specified are

characters left: 30000



If yes, the reason(s) the services(s) was NOT included in my plan is

characters left: 30000



In order to complete the PCP planning process the acknowledgments must be completed unless the consumer has declined participation.

I understand that I have the right to appeal any denial, reduction or termination in service and/or support. Further, I understand that I have the right to an informal or formal appeal and have been given the name(s) of individuals who will assist me in my appeal if desired.

---

I have been informed of informal ways I can resolve conflicts or concerns I may have, including talking to my case manager/supports coordinator/therapist, talking to their supervisor, calling my local Member Service staff, and/or calling the MCCMH Ombudsman at (586) 469-7795 (V/TTY). I have also been given the names of staff I can contact.

---

I have been informed of guidelines for receiving services in this program and discharge procedures.

---

My case manager/supports coordinator/therapist has given me a notice of my hearing rights. If I receive Medicaid, my case manager/supports coordinator/therapist has also given me a Request for Medicaid Fair Hearing Form (found at the end of my printed Person Centered Plan).

---

My case manager/supports coordinator/therapist has given me a copy of the booklet "Your Rights When Receiving Mental Health Services in Michigan".

---

My signature indicates that I directed the planning process with the assistance of those persons I chose to have involved in the process

-or-

Consumer declined to participate in the Person Centered Planning Process. A plan was developed that reflects the services the consumer has/needs.

---

I am aware that I will receive a copy of my Person Centered Plan by mail or delivery within 15 business days and I agree with the plan.

-or-

I am aware that I will receive a copy of my Person Centered Plan by mail or delivery within 15 business days but I disagree with the plan.

Record Added

Record Changed

Save and Continue to Action Notice

Save

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**7. Full PCP: Action Notice**

**Action Notice Medicaid Status**

Medicaid  Non-Medicaid

**Record Added**

**Record Changed**

Save and Continue to Send Copy to

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8. Full PCP: 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**.

- To share a copy of this document with another County / Affiliate click on **Send Copy to County / Affiliate**.

5 Document Copies		Status
Send Copy To / Review By		
<input type="text"/>	<a href="#">lookup</a> <a href="#">clear</a>	
<input type="text"/>	<a href="#">lookup</a> <a href="#">clear</a>	
<input type="text"/>	<a href="#">lookup</a> <a href="#">clear</a>	
<b>Location:</b> <a href="#">lookup</a> <a href="#">clear</a>  <b>Contact Name:</b> <input type="text"/> <b>Purpose:</b> <input type="text"/> <a href="#">?</a>		
<b>Location:</b> <a href="#">lookup</a> <a href="#">clear</a>  <b>Contact Name:</b> <input type="text"/> <b>Purpose:</b> <input type="text"/> <a href="#">?</a>		

[Send to Staff](#)

[Send External Copy](#)

Record Added

Record Changed

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9. Full PCP: Signatures

Consumer left treatment prior to the PCP process being complete (click 'Save' after checking this box)

Service Activity Logs

Staff:	Date:	Contact Type:
Consumer:	Begin:	Attendance:
<input type="text"/>	End: <input type="text"/> <input type="text"/>	Place of Service: <input type="text"/>
<input type="text"/>	<input type="checkbox"/> SAL Spans Midnight	Staff Type: Contract
<input type="checkbox"/> IDDT		
Authorization:		CPT Code: <input type="text"/> <input type="text"/>
Please use the LOOKUP button to find an authorization and CPT code for the service provided		
Was physician on site? (Medicare)		Physician on Site: <input type="text"/>
<input type="radio"/> Yes <input type="radio"/> No		<input type="text"/>

Electronic Signatures

Staff Signature Required By

[Insert Additional Staff Signature Line](#)

Digital Signature To Be Obtained By

To Be Signed By

Digital Signature To Be Obtained By

To Be Signed By

Digital Signature To Be Obtained By

To Be Signed By

Supervisor Signature Required By

Psychiatrist Signature

Record Added

Record Changed