MACOMB COUNTY COMMUNITY MENTAL HEALTH - FOCUS
PERSON CENTERED PLAN - SINGLE SERVICE 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

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

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

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Case Holder:

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2. Details
3. Goals
4. Barriers
5. Authorizations
6. Participation
7. Action Notice
8. Send Copy to
9. Signatures

1. Single Service PCP: Dates

Date of Meeting **Start Time**

Use Current Date

Effective Date **This Plan Expires on** **Next Review Date**

Use Current Date (Maximum of 1 Year) Use Current Date

Save and Continue to Details | Save | CANCEL

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2. Single Service PCP: Details

Plan Development

Describe how the plan was developed and who participated in the development

characters left: 11024

Health and Safety Issues

Describe any pertinent health and safety issues

characters left: 11024

Co-Occurring SUD?

(•) Yes ( ) No ( ) Chooses not to discuss

Stage of Change (Objectives need to correspond)

( ) Pre-contemplative ( ) Contemplative ( ) Preparation ( ) Action ( ) Maintenance

Discharge Planning

Describe what needs to be in place for discharge to occur

characters left: 11024

✓ Spell Check

Record Added **Record Changed**

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

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PCP Goal

Goal Number

1

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

Record Added **Record Changed**

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

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

Address **Primary Program:**
Case Holder:

PCP Goal

Goal Number

2

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

Address **Primary Program:**
Case Holder:

PCP Goal

Goal Number

3

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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Address **Primary Program:**
Case Holder:

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

Record Added **Record Changed**

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

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4. Single Service 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 | CANCEL

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

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Address **Primary Program:**
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 lookup clear			Standard Unit Type
Effective Dates -	Units Per Period *Requested*	Frequency	Total Units *Requested* Calculate
Related Goals			
Notes			
Service lookup clear			Standard Unit Type
Effective Dates -	Units Per Period *Requested*	Frequency	Total Units *Requested* Calculate
Related Goals			
Notes			
Service lookup clear			Standard Unit Type
Effective Dates -	Units Per Period *Requested*	Frequency	Total Units *Requested* Calculate
Related Goals			

Notes

Service lookup clear | Standard Unit Type

Effective Dates - | Units Per Period *Requested* | Frequency | Total Units *Requested* Calculate

Related Goals

Notes

Service lookup clear | Standard Unit Type

Effective Dates - | Units Per Period *Requested* | Frequency | Total Units *Requested* Calculate

Related Goals

Notes

Add More Detail Lines

✓Spell Check

TEST REQUEST | PROCESS REQUEST | SAVE and PEND | CANCEL

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6. Single Service PCP: Participation

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

	Name	Relationship	Present
1			○ Yes ○ No
2			○ Yes ○ No
3			○ Yes ○ No
4			○ Yes ○ No
5			○ Yes ○ No
6			○ Yes ○ No
7			○ Yes ○ No
8			○ Yes ○ No
9			○ Yes ○ No
10			○ Yes ○ No
11			○ Yes ○ No
12			○ Yes ○ No
13			○ Yes ○ No
14			○ Yes ○ No
15			○ Yes ○ 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 | CANCEL

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7. Single Service PCP: Action Notice

Action Notice Medicaid Status

○ Medicaid ○ Non-Medicaid

Record Added **Record Changed**

Save and Continue to Send Copy to | Save | CANCEL

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8. Single Service 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

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 Signatures | Save | CANCEL

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9. Single Service PCP: Signatures

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

Service Activity Logs

Staff: Consumer: If this is **not** the program providing the service, please use the LOOKUP button to select a new program	Date: Begin: End: ☐ SAL Spans Midnight	Contact Type: Attendance: Place of Service: Staff Type:
	☐ IDDT	
	Authorization: - Please use the LOOKUP button to find an authorization and CPT code for the service provided	CPT Code: lookup clear
Was physician on site? (Medicare) ○ Yes ○ No	Physician on Site: lookup clear	

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

Insert Additional Staff Signature Line

Digital Signature To Be Obtained By lookup clear **To Be Signed By**

Digital Signature To Be Obtained By lookup clear **To Be Signed By**

Digital Signature To Be Obtained By lookup clear **To Be Signed By**

Supervisor Signature Required By lookup

Psychiatrist Signature lookup clear

Record Added **Record Changed**

Save CANCEL