Community Mental Health for Central Michigan

PCP

IDENTIFYING INFORMATION				
NAME	DOB	AGE	CASE #	GENDER
ADDRESS				

DATES

DATE OF MEETING START TIME

CONSUMER/GUARDIAN REQUESTS TO COMPLETE PREPLANNING AND PCP MEETING ON THE SAME DAY

☐ Yes ☐ No

IF CONSUMER/GUARDIAN REQUESTS PREPLANNING AND PCP MEETING IN SAME DAY OR IF THERE WAS A CHANGE IN THE PREPLANNED MEETING DATE, VERBAL APPROVAL, OR ANY OTHER CIRCUMSTANCE IMPACTING EFFECTIVE DATE OF THIS PCP PLEASE EXPLAIN

EFFECTIVE DATE

THIS PLAN EXPIRES ON
(Maximum of 1 year)

PARTICIPATION

PEOPLE WHO WERE PRESENT IN MY PERSON-CENTERED PLAN MEETING

	Name	Relationship
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		

DETAILS

WHAT IS THE CONSUMER'S VISION FOR A HAPPY, MEANINGFUL, AND SUCCESSFUL LIFE?
(i.e. dreams, vision of the future, desires, goals, etc.)

PERSON/FAMILY STRENGTHS

What would others who care about you say about you? What would they say are your strengths? What is going well in your life? What resources do you have?

NATURAL SUPPORTS (List any people that are available at no cost to support the consumer, including family, friends and community members.)	
NAME	ROLE AND ASSISTANCE/SUPPORT PROVIDED

IF NO NATURAL SUPPORTS, EXPLAIN

IN WHAT WAYS ARE YOU INVOLVED IN YOUR 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.)

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

DOES THE CONSUMER REQUIRE SUPPORT TO PURSUE THEIR EMPLOYMENT GOALS?

Competitive employment options must be explored first before other types of work options (referral to open jobs, education/training, MI Works, MRS, Individualized Placement Supports, Supported Employment, Skill Building, etc.)

☐ Yes ☐ No

EMPLOYMENT/EMPLOYMENT GOAL(S) COMMENTS (If "Yes" [Consumer chose to receive support/assistance with employment], an employment-specific goal must be incorporated into this Plan).

HEALTH CONCERNS

WOULD YOU LIKE TO INCORPORATE ANY CURRENT HEALTH RELATED CONCERNS INTO YOUR CMH GOALS FOR THIS PLAN OF SERVICE? IF NOT, PLEASE EXPLAIN WHY NOT

CO-OCCURRING DISORDER

CO-OCCURRING?

☐ Yes ☐ No

Stage of Change (Objectives need to correspond)

☐ Pre-contemplative ☐ Contemplative ☐ Preparation ☐ Action ☐ Maintenance

WOULD YOU LIKE TO INCORPORATE ANY CO-OCCURRING RELATED CONCERNS INTO YOUR CMH GOALS FOR THIS PLAN OF SERVICE? IF NOT, PLEASE EXPLAIN WHY NOT

IF YOU HAVE EXPERIENCED TRAUMA, WOULD YOU LIKE TO INCORPORATE A TRAUMA RELATED GOAL INTO YOUR PLAN OF SERVICE? IF NOT, PLEASE EXPLAIN WHY NOT.

HEALTH & SAFETY RISK ASSESSMENT - LAST 5 ASSESSMENT(S) ON OR BEFORE					
Date Collected					

HEALTH & SAFETY RISK ASSESSMENT

☐ No changes since previous Health & Safety Risk Assessment

PRIVILEGED AND CONFIDENTIAL INFORMATION

Not to be disclosed further unless consistent with the authorized purpose for which the information was released

INDICATE THE NEED FOR SUPPORTS IN ANY OF THE FOLLOWING SAFETY DOMAINS

All identified health and safety needs must be pulled forward into a PCP goal, objective, or intervention.

- [ ] Aggressive behavior (hitting, biting, pulling hair)
- [ ] Anger Management
- [ ] Behavioral Safety
- [ ] Fall Risk
- [ ] Homicidal Ideation
- [ ] Inappropriate sexual behavior or history of criminal sexual conduct charge
- [ ] Personal Protection Order (PPO) - in place for someone who has stalked, harassed, or threatened the Consumer
- [ ] Personal Protection Order (PPO) - in place for Consumer against another individual for stalking, harassing, or threatening another individual
- [ ] Relational instability
- [ ] Requires Substantial support to maintain physical wellness, management of chronic conditions
- [ ] Risk of physical/sexual/emotional abuse, neglect, or exploitation
- [ ] Risk related to Eating (Choking risk, binging, purging or restricting food)
- [ ] Self-injurious behavior (Ex: Cutting, burning, head banging)
- [ ] Unsafe neighborhood/living environment
- [ ] Other
- [ ] No current Health and Safety concerns at this time

PLEASE INDICATE WHAT SUPPORTS OR SERVICES HAVE BEEN PUT IN PLACE TO HELP MITIGATE THESE SAFETY DOMAIN AREAS
Please include all natural and community supports including family, friends, community members, and PHCP

WOULD YOU LIKE TO INCORPORATE ANY SAFETY RELATED CONCERNS INTO YOUR CMH GOALS FOR THIS PLAN OF SERVICE? IF NOT, PLEASE EXPLAIN WHY NOT?
(Safety concerns may include safety issues including: abuse, health, community, behavioral, home environment, and relationships)

HABILITATION SUPPORTS WAIVER

IS THIS CONSUMER ENROLLED IN THE HAB SUPPORTS WAIVER PROGRAM?

- [ ] Yes
- [ ] No (If yes, complete the section below. If no, continue to next section.)

After educating the consumer/guardian about all of the service and provider options, please indicate which services they chose to receive below. Providers chosen will be indicated within the authorizations.

HABILITATIVE SERVICES (MUST HAVE AT LEAST ONE.)

- [ ] Community Living Supports (H2016, H2015)
- [ ] Supported Employment (H2023)
- [ ] Out-of-Home Non-Vocational (H2014)
- [ ] Prevocational Services (T2015)

OTHER HABILITATION SUPPORTS WAIVER SERVICES

- ☐ Enhanced Pharmacy(T1999)
- ☐ FamilyTraining (S5111)
- ☐ Personal EmergencyResponse Systems (PERS) (S5160/S5161)
- ☐ Overnight Health and Safety Supports (T2027)
- ☐ Fiscal Intermediary(T2025)
- ☐ Enhanced Medical Equipment & Supplies (E1399, T2028, T2029, S5199, T2039)
- ☐ Environmental Modifications (S5165)
- ☐ Respite Care (T1005, H0045)
- ☐ Non-FamilyTraining (S5116)
- ☐ Goods & Services (Must have Self-Determination arrangement & utilize a fiscal intermediary. See Medicaid Provider Manual) (T5999)
- ☐ Private Duty Nursing (Must meet PDN criteria and be approved by MSHN and MDHHS) (S9123, S9124, T1000)

COMMENTS

:

☐ MichiCANS Not Applicable

PCP Goal

Goal Number:

Goal:
What person needs to accomplish; a reasonable step towards a desired outcome for the future that directs the support and services CMHCM can provide

Implementation Date: Target Date:

Stage of Change (Objectives need to correspond)
☐ Pre-contemplative ☐ Contemplative ☐ Preparation ☐ Action ☐ Maintenance ☐ N/A

PCP Objective

Objective Letter
Observable and measurable steps toward attainment of goal

Objective:

Implementation Date: Target Date:

Intervention/Supports
Describe the type of actions that CMHCM 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)

BARRIERS

WHAT ARE SOME OF THE BARRIERS THAT MIGHT GET IN THE WAY OF YOU ACCOMPLISHING THESE GOALS?

MONITORING PROFESSIONAL

HOW OFTEN WILL A REVIEW OF PROGRESS BE COMPLETED ON ALL OF THE CONSUMER'S GOALS AND OBJECTIVES

REFERRALS
WAS A REFERRAL MADE DURING THIS CONTACT? ☐ Yes ☐ No REFERRAL COMMENTS

ONCE YOU HAVE ACCOMPLISHED THESE GOALS, WHAT SUPPORTS WOULD BE NECESSARY FOR YOUR RECOVERY JOURNEY?

QUALITY OF LIFE
AT THIS TIME ARE ANY OF THE FOLLOWING SERVICES BEING REQUESTED: SKILL BUILDING (H2014, H2014 TT), OUT OF HOME NON-VOCATIONAL SERVICE (HSW SERVICE) (H2014 , H2014 TT), PREVOCATIONAL SERVICE (T2015, T2015 TT), OR SUPPORTED EMPLOYMENT (H2023, H2023 TT)? ☐ Yes ☐ No
AT THIS TIME ARE SERVICES BEING REQUESTED THAT WILL BE PROVIDED IN A LICENSED SETTING (H2016) OR AN UNLICENSED SETTING OWNED BY THE PROVIDER OF SERVICE (H0043 (WITH OR WITHOUT MODIFIERS TF, TG, OR TT) OR H2015, H2015 TT)? ☐ Yes ☐ No

AUTHORIZATION

Provider:

Authorization Effective Date: Authorization Expiration Date:

Notes:

Service Description:

Effective date from _____ to _____

Units per Period from _____ to _____

Period frequency: _____Day _____Month _____Quarter _____Auth _____Week _____Year

How will the service be provided?
☐ Face to face with Consumer Only ☐ F-to-F with Consumer & others ☐ F-to-F with others only ☐ Staff only

Where will the service be provided?
☐ Consumer's Residence ☐ Community Setting ☐ CMHCM Office ☐ Other :_____

SERVICE RELATES TO GOAL NUMBER(S):

Service Description:

Effective date from _____ to _____

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☐ Face to face with Consumer Only ☐ F-to-F with Consumer & others ☐ F-to-F with others only ☐ Staff only

Where will the service be provided?
☐ Consumer's Residence ☐ Community Setting ☐ CMHCM Office ☐ Other :_____

SERVICE RELATES TO GOAL NUMBER(S):

INFORMAL CONFLICT RESOLUTION

I understand that if I am not in agreement with my person-centered plan or I have other conflicts with my services, I may request at any time, informal problem-solving and/or conflict resolution with _____ or with Customer Service at (800) 317-0708. I may also contact Customer Service if I desire more information about my rights, agency operations, services, provider network, grievance & appeals process, and interpretation services.

The Amount of Service You Receive:
Sometimes it is hard to know how much of a service you might need in the future. Things can go better or worse, faster or slower, or differently than we might be able to plan now. To handle these situations, when service rules allow us to do it, we may decide together to put a low and high number for how often or how much of a service you will receive. Whether we do this, you will always get at least the lowest amount of the service we decide on. You can get up to the highest amount we decide on if you need it, and any amount in between. During all of the time we work together, we will talk about your mental health needs and make sure that we are providing enough services to meet them.

CONSUMER BUDGET SUMMARY

As part of your PCP that you completed through a person-centered planning process, the cost for each service and support is estimated. This is only a cost estimate, it is not a bill required to be paid. It is subject to change based on your needs. The total estimated costs for services is $

Notice Medicaid Status
☐ Medicaid ☐ Non-Medicaid

IF YOU DO NOT AGREE WITH OUR ACTION, YOU HAVE THE RIGHT TO AN INTERNAL APPEAL.

You must ask CMH for Central Michigan for an Internal Appeal within 60 calendar days of the date of this notice. You, your representative, or your doctor can send in your request that must include:

- Your Name
- Your Address
- Your Member Number

• Your Reason for appealing
• Whether you want a Standard or Expedited Appeal (for an Expedited Appeal, explain why you need one).
• Any evidence you want us to review, such as medical records, letters from your physicians, or other information that explains why you need the item or service. If you are asking for an Expedited Appeal, you will need a physician's supporting statement. Call your physician if you need this information.

Please keep a copy of everything you send us for your records.

There are 2 kinds of internal appeals:

Standard Appeal: You will be given a written decision on a Standard Appeal within 30 calendar days after your Appeal is received. Our decision might take longer if you ask for an extension, or if we need more information about your case. You will be told if extra time is being taken and will receive an explanation why more time is needed. If your Appeal is for payment of a service you have already received, you will receive a written decision within 60 calendar days. If you want to ask for an Internal Appeal, you can either call or send in a written request to:

CMH for Central Michigan
301 South Crapo Street, Mt. Pleasant, MI 48858
Phone Number: (989)772-5938 or (800)317-0708
TTY: Michigan Relay at 7-1-1
Fax Number: (989)773-1968

Expedited Appeal: You will be given a decision on an Expedited Appeal within 72 hours after your Appeal is received. You can ask for an Expedited Appeal if you or your physician believe your health could be seriously harmed by waiting up to 30 calendar days for a decision. You will automatically be given an Expedited Appeal if your physician asks for one for you or if your physician supports your request. If you ask for an Expedited Appeal without support from your physician, the State will decide if your request requires an Expedited Appeal. If you are not given an Expedited Appeal, you will be given a decision within 30 calendar days. To ask for an Expedited Appeal, you must call: (989)772-5938 or (800)317-0708. TTY users call Michigan Relay at 7-1-1.

CONTINUATION OF SERVICES DURING AN INTERNAL APPEAL

If you are receiving a Michigan Medicaid service and you file your Appeal within 10 calendar days of this Notice of Adverse Benefit Determination (05/26/2024), you may continue to receive your same level of services while your Internal Appeal is pending, and should submit to the CMH for Central Michigan. Your benefits for that service will continue if you request an Internal Appeal within 10 calendar days from the date of this notice or from the intended effective date of the proposed adverse action, whichever is later.

IF YOU WANT SOMEONE ELSE TO ACT FOR YOU:

You can name a relative, friend, attorney, physician, or someone else to act as your representative. If you want someone else to act for you, call us at (989)772-5938 or (800)317-0708 to learn how to name your representative. TTY users, call Michigan Relay at 7-1-1. Both you and the individual you want to act for you must sign and date a statement confirming this is what you want. You will need to mail or fax this statement to us. Keep a copy for your records.

ACCESS TO DOCUMENTS

You and/or your authorized representative are entitled to reasonable access to and a free copy of all documents relevant to your appeal any time before or during the Appeal process. You must submit the request in writing.

WHAT HAPPENS NEXT?

- If you ask for an Internal Appeal and are continually denied your request for coverage or payment of a service, you will be sent a written Notice of Appeal Denial. If the service is covered by Michigan Medicaid, you can ask for a Medicaid State Fair Hearing.
- The Notice of Appeal Denial will give you additional information about the State Fair Hearings process (or Patient Right to Independent Review Act) and how to file the request.
- If you do not receive a notice or decision about your internal appeal within the timeframes listed above, you may also seek a State Fair Hearing with the Michigan Office of Administrative Hearings and Rules (MOAHR).

Get Help & More Information

If you need help or additional information about the decision and the Internal Appeal process, call

CMH for Central Michigan Customer Service Department
Phone: (989)772-5938 or (800)317-0708
TTY: Michigan Relay at 7-1-1
Our hours of operation are Monday-Friday, 8:00 AM to 5:00 PM
You can also visit our website at www.cmhcm.org
MDHHS Beneficiary Help Line: 1-800-642-3195. TTY users call 1-866-501-5656 or 1-800-975-7630 (if calling from an internet based phone service).

The legal basis for this decision is 42 CFR 440.230(d), Michigan's Mental Health Code, Public Act 258, and/or applicable policy found in the Medicaid Provider Manual, Mental Health and Substance Abuse Services. These provide the basic legal authority for us to place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures.

STATEMENT OF RIGHTS

☐ I understand that I have the right to appeal any denial, reduction or termination in service and/or support provided by CMHCM. I understand if the request for appeal is made within 10-days of determination, I can request for services to be maintained during the appeal process for services previously authorized. I understand that I have the right to an informal appeal process and can contact Customer Service at (989)772-5938 to obtain further information.

☐ I have been informed of the guidelines for receiving services, as well as discharge procedures in this program.

☐ My signature indicates that I am directing the planning process with the assistance of the individuals I have chosen to be involved in this process.

Please select only ONE of the following:

☐ I am aware that I will receive a copy of my Person-Centered Plan by mail or by hand delivery within the next 14 calendar days, and I AGREE with this plan of service.

☐ I am aware that I will receive a copy of my Person-Centered Plan by mail or by hand delivery within 14 calendar days, however I DISAGREE with this plan of service.

Consumer/Guardian was not present at the time of the PCP/Addendum. A copy of the PCP/Addendum will be sent within 14 calendar days along with a Notice of Benefit Determination explaining any changes in CMHCM service(s).

SIGNATURES

STAFF SIGNATURE / CREDENTIALS	DATE

CONSUMER SIGNATURE	PRINTED NAME	DATE

GUARDIAN SIGNATURE	PRINTED NAME	DATE

SUPERVISOR SIGNATURE / CREDENTIALS	DATE

The signatures above indicate knowledge and agreement with goals, interventions, services, strategies, outcomes, frequency, and responsible person designated in this plan. This Plan will be reviewed at least semi-annually.