

# Northern Affiliation

Documentation

Policy and Procedures Manual

**“DRAFT”**

Revised Version August 2003

(Changes to the current Preliminary Person Centered Plan, Person Centered Plan, Person Centered Plan Addendum and Person Centered Plan Review)

All previous versions are obsolete

## **NORTHERN AFFILIATION**

### **STANDARDIZED CLINICAL RECORD FORMS**

Versions dated prior to August 2003

#### **Policy:**

All services authorized and reimbursed by the Northern Affiliation require all providers to utilize only Northern Affiliation approved forms to document clinical information in consumer records.

#### **Scope of Policy:**

Northern Affiliation has developed a standardized set of clinical forms for use by all providers. Service providers must use these forms in a uniform and consistent manner. These forms help establish and document the medical necessity and/or therapeutic benefit of services provided in accordance with the principles and philosophy of Person-Centered Planning. Workers complete forms on the date of service or by the end of the next working day at the latest.

The current nine forms are:

- A. Access Screening Form
- B. Intake/Annual Assessment
- C. Pre-Planning Process\*
- D. Plan of Service\*
- E. Plan of Service Addendum\*
- F. Plan of Service Review\*
- G. Progress Note/Activity Note
- H. Intake/Annual Assessment Addendum
- I. Discharge/Transfer/Continuity of Care Plan Summary
- J. Crisis Plan Worksheet\* (Optional)
- K. Reference sheet on Medicaid Managed Specialty Supports and Services Concurrent 1915 9b0

*Indicates a revision of the previous form*

## Standardized Clinical Documentation Procedures

The purpose of these procedures is to provide an explanation of how each Northern Affiliation clinical documentation form is to be utilized. Instructions follow for each of the nine primary clinical forms related to the development, implementation, monitoring, and revision of consumer Plan of Service documents.

### Definitions and Procedures

#### A. **Access Screening Form:**

The Access Screening Form provides Northern Affiliation Access to Care workers a standardized process to screen and triage consumers, to assess acuity of care needs, develop a diagnostic impression and make a timely referral to the Provider Network.

**These form elements may be completed telephonically at the Northern Affiliation Access to Care Center, face-to-face at the Access Center or at a provider location.**

1. **If Emergency, phone # of present location:** In emergency situations, the worker asks consumer or caller to provide phone number where they are calling from in order to establish phone reconnection if required.
2. **Consumer Name:** Enter the last name of the consumer and suffix, first and middle initial. Use of only the first or last name is not adequate for consumer identification.
3. **Maiden/Alias:** Enter the consumer's maiden name, if applicable, and enter any "alias" names consumer may have or continues to use. This critical information helps determine if the consumer has been previously served by the agency.
4. **Address:** Enter street address (along with apartment number) or P. O. Box, City, State and Zip Code of consumer's residence.
5. **Alternate Address:** If consumer receives mail at another address, enter street address (along with apartment number), P.O. Box, City, State, and Zip Code.
6. **Home Phone#:** Worker enters consumer's home phone number and indicate if consumer approves for staff to identify him/herself as a Northern Affiliation staff member when they call to leave a message.
7. **Message #:** Worker enters consumers phone message number and indicate if consumer approves for staff to identify him/herself as a Northern Affiliation staff member when they call to leave a message.
8. **Work #:** Worker enters consumer's work phone number, if applicable, and indicates if consumer approves for staff to identify him/herself as a Northern Affiliation staff member when they call to leave a message.
9. **Sex of Consumer:** Worker checks appropriate box.

10. **DOB:** Worker enters the consumer's date of birth by month, day, and four-digit year.
11. **Age:** Worker enters consumer's current age.
12. **Social Security Number:** Worker enters the consumer's social security number.
13. **Referred By:** Worker indicates referral source. State "self" if consumer has independently sought services.
14. **Caller:** The worker identifies the caller if other than the consumer. Complete last name, first name, and middle initial. If consumer, leave blank.
15. **Relationship:** Identify the relationship the caller has to the consumer.
16. **Legal Guardian:** Worker enters the name and phone number of the consumer's legal guardian, if applicable.
17. **Address:** Enter address of legal guardian if applicable.
18. **In Case of Emergency:** Enter the name and phone number of the person the consumer wants to utilize as an emergency contact.
19. **Address:** Indicate the emergency contact's street address, apartment number, City, State, Zip Code.
20. **Insurance Company:** If the consumer has private insurance, identify the name of the company.
21. **Policy #:** Give policy number of the consumer's private insurance.
22. **Medicaid #:** Worker records consumer's Medicaid ID number, if applicable.
23. **HMO/QHP:** If consumer has Medicaid, worker determines if he/she is enrolled in a HMO/QHP. This information can be found on the Medicaid ID card. If consumer is not enrolled in an HMO/QHP, leave blank. This indicates that consumer has fee-for-service Medicaid coverage.
24. **Medicare #:** If consumer has Medicare, enter the ID number. If a client has both Medicare and Medicaid, he/she will **not** be enrolled in an HMO/QHP.
25. **Other:** If consumer has another type of insurance, please identify.
26. **None:** Check this box if the consumer has no health insurance coverage.
27. **County of Liability:** This is the county where the consumer last lived independently before entering dependent (licensed foster care facility, state institution) care. This is the current county of residence if consumer is not living in a licensed foster care home or institution.
28. **Pregnant:** Check "yes" or "no" based on consumer response.
29. **Presenting Issue:** Worker summarizes the consumer-furnished information and/or collateral information received regarding consumer's complaint, problem, or presenting issue.
30. **Prior Hospitalization/Treatment:** Worker enters a summary of prior

behavioral/developmental disability health care received by the consumer.

31. **Current Medications:** Worker lists all current medications and dosages.
32. **Prescribing Physicians:** Worker enters the names of consumer's prescribing physicians.
33. **Injecting Drug Use Within 30 Days:** Worker indicates any use of drugs via injection within the last 30 days by checking appropriate box.
34. **Recent Substance Abuse:** Worker indicates recent substance abuse issues in consumer's life.
35. **Danger to Self:** Worker check the appropriate boxes or "none" regarding whether consumer has thoughts, plan and/or means to carry out a plan to endanger self. If a box other than "none" is selected, the worker must add descriptive narrative.
36. **Danger to Others:** Check the appropriate boxes or "none" regarding whether consumer has thoughts, plan and/or means to carry out a plan to endanger others. If a box other than "none" is selected, the worker must add descriptive narrative.
37. **Other Risk Factors:** Check the appropriate boxes or "none" to indicate if the consumer displays any other risk factors. If a box other than "none" is selected, the worker must add descriptive narrative.
38. **Overall Risk/Priority:** Based on all of the information provided by consumer, or consumers' guardian, family members/friends, worker indicates the overall risk that the consumer is experiencing and checks the specific Access to Care referral time line that needs to be followed and monitored. The worker uses the following Acuity of Symptoms Checklist for the determination of "routine," "urgent," or "emergent."

**Acuity of Symptoms for the determination of Routine:**

- a. The consumer has vague or undifferentiated suicidal (violent) ideation and impulses and;
- b. Acknowledges subjective ability to control the impulses; and
- c. No serious indications of reduced impulse control, i.e., current psychosis or substance abuse; and
- d. Able to agree or contract to follow through with a prescribed referral.

**Acuity of Symptoms for the determination of Urgent:**

- a. The consumer has suicidal (violent) impulses; and
- b. Presents evidence of being able and willing to control impulses; and
- c. The consumer expresses suicidal (violent) ideation with an indefinite plan;
  - time and place are vague or ill-defined; and
  - method is either vague or not readily available; and

- d. No serious indications of reduced impulse control due to current psychosis or substance abuse; and
- e. The consumer has made a medically non-lethal gesture or threat of self-harm (harm to others); and
- f. Overt intent to die or seriously injure someone else is absent; and
- g. Support system in the community is marginal or weakened by current stressor(s), but may remain intact, or be available at a later date; and
- h. Consumer is pregnant.

**Acuity of Symptoms for the determination of EMERGENT**

- a. The consumer has strong suicidal (violent) impulses and presents evidence of not being able to control those impulses, due to mental illness, substance abuse, or feelings of hopelessness; and/or
- b. The consumer expresses the intention to die or seriously harm someone else and has a definite plan and means to carry it out; and/or
- c. The consumer is acutely psychotic and has acute suicidal (violent) ideation of any degree; and/or
- d. The consumer had made a medically very serious attempt or threat with some suggestion of intent to die or seriously inflict harm on other(s); and/or
- e. There is an escalating pattern of suicidal (violent) ideation, threats, or attempts; and/or
- f. According to current presentation, vegetative signs (sleep, appetite, and weight changes, experience of pleasure, etc.) are severely impacted; and/or
- g. Support system in the community is non-existent or exhausted.

39. **Access Status:** Worker indicates if the consumer is "accepted" into care, is a "Readmit" (had received services from the agency within the previous six months), "referred elsewhere" to services, "denied" services." If the consumer is denied services, worker must indicate if Right of Appeal was explained to the consumer.

40. **Disposition:** Worker checks the appropriate box to determine type of referral for face-to-face intake.

41. **Previous Preferred Provider:** Worker checks the appropriate box to indicate if the consumer has a previous preferred provider to whom they would like to be referred for their current treatment needs. If "yes," the provider must be identified.

42. **In Network:** Worker determines if the consumer's preferred provider is a member of the Northern Affiliation Provider Network Panel. If "yes," provider is identified.

43. **Appointment with:** Indicate the provider name, date and location of appointment.

44. **Date Offered:** This line requires the worker to note the appointment date initially offered to consumer, date requested by consumer, date of appointment actually given or accepted by consumer time and location of the appointment with the provider.
45. **Appointment with:** Indicate the provider name, date and location of appointment on this line if Access Staff gives the consumer appointments with an additional provider.
46. **Date Offered:** This line requires the worker to note the appointment date initially offered to consumer, date requested by consumer, date of appointment actually given or accepted by consumer time and location of the appointment with the provider.
47. **Caller Advised of the Following:** Worker indicates by checking the appropriate boxes what information or instructions were given to the consumer (or caller, if caller is not the consumer).
48. **How did you hear about us?** Worker indicates the source of information that caused the consumer to contact Northern Affiliation.
49. **Completed By/Title:** The worker completing the Access Screening Form signs and provides his/her title/licensure.
50. **Start Time:** Enter the start time of the access screening service
51. **Stop Time:** Enter the stop time of the access screening service.
52. **Face-to-Face or Telephonic Screening:** Worker checks the applicable box.
53. **Location:** Enter the location where the service took place.
54. **Service Code:** Enter the service code for the Access Screening service.
55. **Cost Center:** Enter the actual cost center to which the Access Screening should be charged.

## **B. INTAKE/ANNUAL ASSESSMENT FORM**

The Intake/Annual Assessment form (Revised 9/02) provides a standardized process by which workers can gather essential consumer information necessary for the development of a Person-Centered Plan. The Intake/Annual Assessment form is also designed to collect information required by both accreditation and contractual sources and all sections must be completed annually as indicated. **This revision provides for an age specific assessment and the paging of the document is divided according to the following format:**

### **Mandatory:**

Section 1 – Demographics

#### **Select 2a, 2b or 2c (mandatory)**

Section 2a – Adult Health Screening

Section 2b – Child/Adolescent Health Screening

Section 2c – Infant's Birth Health Screening

#### **Select 3a or 3b (mandatory)**

Section 3a – Adult Assessment

Section 3b – Child and Adolescent Assessment

#### **Complete 4 and 5 as needed**

Section 4 – Mental Status Summary

Section 5 – Consumer Chemical Use History

### **Mandatory**

Section 6 – Diagnosis, Disability and Service Designation

The form is used for both the initial intake assessment and for annual assessment updates. **The worker circles "Intake" or "Annual" or checks the "Intake" or "Annual" box at the bottom of the form. It is suggested that the sections of the assessment be grouped according to age specific consumers, i.e., a packet for Adult Assessments and one for Children/Adolescent.**

Consumers may choose not to answer questions they consider personally invasive. Workers must be sensitive to consumer personal beliefs, values, feelings, anxiety, and desire for privacy.

Much of this form can be completed by worker and consumer (or their parent/legal guardian) working

together. At worker discretion, the health screening portion of the form may be given directly to the consumer to complete and bring to the intake appointment.

## **Section 1**

1. **Living Arrangements:** Worker or consumer checks the box which best describes the consumer's current living arrangements. Workers must be certain that the last question, which requires a narrative statement, is completed. If the individual is currently living in a dependent care situation (facility, licensed foster care), what was the last residential address at which they lived independently? This is critical information for determining county of financial liability.
2. **Marital Status:** Worker or consumer checks appropriate box.
3. **Ethnic Background:** Worker checks appropriate box based upon the consumer's response. If consumer chooses to not provide this information, box #9 is checked.
4. **List Household Members:** Worker, based on consumer provided information, lists all household members in this section, giving name, relationship, and age. List the consumer in the first box. Also list the name, address and phone number of the **next of kin** in the appropriate space.
5. **Employment:** Worker or consumer checks the box that reflects consumer's current employment status. Item 04, "I am unemployed, not looking for work," per current DCH contract language, is defined as "not in the competitive labor force"—includes homemaker, student age 18 and over, day program participant, resident or inmate of an institution (including nursing home).
6. **Military Experience:** Worker or consumer will indicate in the Military Experience table if s/he is a veteran and if yes, if s/he has combat experience by checking the appropriate "yes" or "no" boxes. Additionally, if consumer indicates s/he is a veteran, s/he will need to indicate the year they were drafted or year they enlisted, the year of discharge, type of discharge and highest rank obtained.
7. **Education:** Worker or consumer will check the appropriate box to indicate education status. If the consumer cannot or will not provide this information, the "unreported" box is checked.
8. **Legal/Corrections Related Status:** Worker or consumer will check the applicable box or boxes. This section is for individuals who are under the jurisdiction of a corrections or law enforcement program at the time of screening, intake or annual assessment. For those individuals for whom it **does not apply**, please check box #07.

**Section 2a – Adult Health Screening:** This section may be completed by the consumer with the worker, or may be given directly to the consumer to complete. Consumers may choose not to answer specific questions and may leave those lines blank. The worker should note that the consumer made this choice, so that there is no question about his/her intent.

**Section 2b – Child/Adolescent Health Screening:** This section must be completed for children

from 4 to 18 yrs. old.

**Section 2c - Infant's Birth – Health History:** This section must be completed for children from birth to 3 yrs. old.

**Section 3a – Adult Assessment:**

1. **Worker:** Worker completing the Intake/Annual Assessment enters name.
2. **Identifying Data:** Worker writes a brief summary narrative about the consumer. In addition to prompts, this should include a description of the consumer's behavior, mood, appearance, language, mobility, communication skills and style.
3. **Presenting Concerns:** The worker uses this text box to record the consumer's stated concerns, reasons for seeking treatment, and desired outcomes.
4. **Psychiatric History:** Worker enters information about consumer's previous treatment by psychiatrists, psychiatric hospitalizations, family psychiatric history, including suicide.
5. **Current Medications:** Include both prescribed and over-the-counter.

**Social History:** There are several sections under this heading, which must be completed by the worker with input from the consumer, guardian, family members, or others as is necessary and appropriate. For each section, the worker enters a narrative summary.

6. **Psychosocial History/Communication/Family and Social Life/Education/Employment/Military:** Worker enters information regarding the consumer's history; language, language skills, abilities, needs and readiness, difficulties hearing or speaking, sign language proficiency, augmentative communication equipment used; patterns of discipline, unusual trauma, losses; relationships, experience and perception of their family life, marital status, next of kin, behaviors, roles, patterns of interaction, strengths, values and beliefs; level of education, school/s attended, (schools need not be listed except for children under 18 years of age or students who qualify under state law for public education until age 26), current school attended must be listed, current grade; current employment history, types of work, duration, particular work skills or interests, abilities; military experience.
7. **Supports and Concerns: Basic Needs/Spiritual/Cultural/Leisure-Recreation/Interpersonal Relationships/Financial/Gambling:** Information regarding basic needs, if applicable, in the areas of food, clothing, transportation and living arrangements. Workers must give considerable detail for consumers with severe developmental and/or cognitive disabilities or chronic, serious mental illness; spiritual beliefs, practices and preferences; cultural beliefs, practices and preferences; leisure and recreational activities, types, special interests, any barriers to enjoyment and/or community inclusion; interpersonal relationships with friends, co-workers, others, if consumer wishes; consumer's financial status, financial security, large debt load, credit history, financial worries, financially independent, dependent on SSDI, SSI; impact, if any, of gambling on life. Recreational, occasional, frequency, heavy debt related to gambling. Does consumer indicate if others have expressed concern about his/her gambling?

8. **Legal:** Information regarding guardianship, if applicable. Notes extent of guardianship (plenary, partial, conservatorship), type of guardianship (Legally Incapacitated Person or LIP, Developmentally Disabled Person or DDP), probate court of jurisdiction for the guardianship.
9. **Safety/Abuse-Neglect/Adaptive Equipment/Environmental Modifications/ Mobility-Ambulation/Other Risk Factors:** Information regarding consumer safety skills, awareness, particular areas of vulnerability; experience of abuse-neglect in their life. Are they currently at risk? Information about any adaptive equipment used, such as wheelchairs, side lyers, tilt tables, lifts, etc. Any special environmental modification used or needed to support consumer to live as independently and safely as possible. These may include, but are not limited to, such items as wheelchair ramps, grab bars, telephone or electronic life lines, wheelchair accessible showers, special lifts, specific barrier-free home design.

### **Section 3b – Child and Adolescent Assessment**

1. **Worker:** Worker completing the Intake/Annual Assessment enters name.
2. **Identifying Data:** Worker writes a brief summary narrative about the consumer, following the prompts.
3. **Presenting Concerns:** The worker records the consumer's stated concerns.
4. **Psychiatric History:** Worker enters information about consumer's previous treatment by psychiatrists, psychiatric hospitalizations, family psychiatric history, including suicide.
5. **Current Medications:** Include both prescribed and over-the-counter.

**Social History:** There are several sections under this heading, which must be completed by the worker with input from the consumer, guardian, family members, or others as is necessary and appropriate. For each section, the worker enters a narrative summary.

6. **Psychosocial History/Communication/Family and Social Life/Education/ Leisure-Recreation:** Worker enters information regarding the consumer's history; language, language skills, abilities, needs and readiness, difficulties hearing or speaking, sign language proficiency, augmentative communication equipment used; patterns of discipline, unusual trauma, losses; relationships, experience and perception of their family life, behaviors, roles, patterns of interaction, strengths, values and beliefs; level of education, school/s attended, (schools need not be listed except for children under 18 years of age or students who qualify under state law for public education until age 26), current school attended must be listed, current grade.
7. **Supports and Concerns:** Basic Needs/Spiritual/Cultural/Financial/Gambling: Information regarding basic needs, if applicable, in the areas of food, clothing, transportation and living arrangements. Workers must give considerable detail for consumers with severe developmental and/or cognitive disabilities or chronic, serious mental illness; spiritual beliefs, practices and preferences; cultural beliefs, practices and preferences; consumer's financial status, financial security, large debt load, credit history, financial worries, financially independent, dependent on SSDI, SSI; impact, if any, of gambling on life. Recreational,

occasional, frequency, heavy debt related to gambling. Does consumer indicate if others have expressed concern about his/her gambling?

- 8. Safety/Abuse-Neglect/Adaptive Equipment/Environmental Modifications/ Mobility-Ambulation/Other Risk Factors:** Information regarding consumer safety skills, awareness, particular areas of vulnerability; experience of abuse-neglect in their life. Are they currently at risk? Information about any adaptive equipment used, such as wheelchairs, side lyers, tilt tables, lifts, etc. Any special environmental modification used or needed to support consumer to live as independently and safely as possible. These may include, but are not limited to, such items as wheelchair ramps, grab bars, telephone or electronic life lines, wheelchair accessible showers, special lifts, specific barrier-free home design.

**Section 4 - Mental Status Summary:** - The worker checks the box that best corresponds with their assessment of the consumer's condition. An optional "comments and observations" section is provided. Must use this to establish a psychiatric diagnosis.

**Section 5 – Consumer Chemical Use History** section of the mental status exam is designed (as other sections are) to provide a current, not a historical view of the consumer's difficulties, concerns, strengths, and weaknesses. *If the consumer denies using alcohol or drugs, the worker does not need to complete the Chemical History section, which follows.*

- 1. Consumer Data Questionnaire/Chemical Use History:** This section conforms to the specific standards contained in the "Administrative Rules for Substance Abuse" programs as delineated by the Michigan Department of Community Health, Division of Substance Abuse services. The information collected helps provide a basis for determining the appropriate treatment. When this section is used: Drug Category: Select each substance used by placing a P for primary drug of choice, an S for secondary drug of choice, or T for tertiary drug of choice in the box below the identified substance. Under several categories, more space is provided to identify the particular type of the overall substance used. The Year/Age of First Use is the actual year the consumer started using that particular substance. Workers often find it more useful to identify how long the individual has in fact been using the particular substance. Frequency of Use: check the box that most closely describes how frequently the consumer is using the particular substance. Current Use/Abuse: Check box if used in the past 48 hrs. and the types used/abused. Note amount used. Method of Use: check the box that most closely describes how the substance is taken. Previous Overdose, Withdrawal or Adverse Reactions: worker checks "yes" or "no" and describes briefly what happened. The worker asks the consumer: "Are you bothered by others' concerns about your drug use?" If "yes" the worker adds narrative explanation. Symptoms: The worker checks all applicable boxes.
- 2. Impact:** The worker briefly describes the overall impact the consumer's use appears to have had on their family, work, school, etc.
- 3. Previous Treatment:** The worker briefly describes what, if any, treatment the consumer has received with alcohol or other drug problems.

4. **ASAM Placement Dimensions:** The worker completes this section only for consumers who are receiving Substance Abuse Services. Using the Clinical Reference Sheet, the worker identifies the particular level of difficulty the person is having and provides evidence in support.

## **Section 6**

1. **Assessment Tools:** The worker identifies those specific instruments that have been used to measure the consumer's difficulties, concerns, strengths and weaknesses. Worker may enter narrative explanation.
2. **Summary and Justification of Diagnosis:** The worker enters a narrative summary of the diagnostic information and gives justification of diagnosis. If the worker is not the diagnostician (e.g. case manager/supports coordinator), the worker may simply make reference to the source document/s. This would typically involve citing the most recent psychological evaluation and/or psychiatric review.
3. **Diagnostic Formulation:** The worker reports Axis I, II, and III DSM-IV codes, noting which diagnosis is the principal diagnosis (focus of current treatment). Some consumers may have more than one diagnosis on the first three Axes; the diagnostician must indicate which is the primary diagnosis for each Axis. Check boxes are provided for Axis 4 conditions. Space is provided for Axis 5 GAF or GAS scores. If the worker completing this form is not credentialed/privileged to diagnose, the source for this information must be clearly identified; name of professional, professional's licensure/registration, date of source report.
4. **Integrated Summary of Assessed Clinical Needs:** Based on all the information gathered as part of the assessment (consumer interviews, role performance profiles, guardian/family input, worker review of records, worker review of health history, worker clinical observation) the worker summarizes the consumer's needs, strengths, limitations and identifies barriers to treatment. This summary is key to the development of both preliminary and full person-centered planning with the consumer.
5. **Treatment Recommendation:** The worker makes specific recommendations for treatment to address the consumer's presenting concerns, issues.
6. **Disability/Service Designation:** This section includes Disability Designation and Service Designation boxes to be checked as applicable. More than one box may be checked for Disability/Service, *but there must be substantiating diagnoses*.
7. Check the boxes of the sections used in this Intake/Annual Assessment.

**Signatures:** CMH Intake Worker and Supervisor sign and date the form. There are lines for other individuals to sign as is necessary or required (guardian, consumer, physician, other).

**Consumer Name/Birth Date/ID#/Date:** Worker notes consumer's full name, date of birth, consumer agency ID, and date of Intake or Annual Assessment.

## C. Pre-Planning Process Form

Person-Centered Planning does not begin with the Plan of Service meeting. PCP Principles and DCH requirements **mandate** a pre-planning process. Per the October 2002 Person-Centered Planning Revised Policy Practice Guideline, Attachment P 3.4.1.-1Section III, PCP Practice Guidelines, Part A Essential Elements, item 5 clearly states that a pre-planning meeting is required and lists the minimum necessary items to be addressed:

“Before a person-centered planning meeting is initiated, a pre-planning meeting occurs. In pre-planning the individual chooses:

- a. Dreams, goals, desires and any topics about which he/she would like to talk
- b. Topics he/she does not want discussed at the meeting
- c. Who to invite.
- d. Where and when the meeting will be held
- e. Who will facilitate.
- f. Who will record.

The Pre-Planning Process form consists of two pages. This form reflects a critical part of the consumer’s Person-Centered Planning process. The individual may seek and receive assistance from family members, friends, advocates, guardian and/or worker. The form act as an assist and prompt for the consumer and worker in identifying issues of concern, personal preferences for how, when and where the PCP meeting will be held.

This form is to be used when:

- a. When an individual seeks services for the first time,
- b. Prior to the annual treatment planning process and
- c. Whenever a consumer requests that the treatment team/planning process be reconvened.
- d. When staff, treatment team desire or recommend that the planning team reconvene.

**The intent of this form is to ensure that the process of Person Centered Planning is followed.**

The Pre-Planning Process form is filed with the final Plan of Service in the chart when the Plan of Service is complete. *The CMHSP should be named at the top of the form instead of the generic Community Mental Health.*

1. **Identify which services/supports, including alternative services, if applicable, you would like from CMH.** *If person does not desire services, document and ensure individual knows process to re-access services as desired or as needed in the future. (Alternative Services are listed in the Medicaid Managed Specialty Supports and Services Concurrent 1915 (b) (c)Waiver Program FY 03-04 page 24; other references include program brochures, and consumer handbook) Please utilize the available.*

2. **Are there any dreams, goals, desires, or topics you would like to discuss?** Discuss with the consumer his or her dreams, goals, desires. And which of these does he or she desire to talk about at the upcoming planning meeting. Help the individual “dust off some dreams” Develop a dream and desire (vision or picture of what the individual would like his or her life to look like) Help the individual to remember that dreaming, desiring and obtaining is possible even when living with the challenges of a disability. Briefly record the consumer’s dreams and desires, and what he or she would like to talk about at the planning meeting
3. **What do you do well?** Record what the consumer reports he or she does well and what staff and self have noted or reported that the consumer does well. Often persons living with a disability may think they don’t do anything well. This is an opportunity to offer education and support.
4. **What do you want to do better?** Begin the process of building a treatment plan How can CMH services, supports and staff help you make the improvement you desire?
5. **Increasing community involvement/inclusion?** Inquire about community activity and involvement and whether the consumer is desirous of more involvement and utilization of community resources. This is an opportunity to provide education .
6. **Are there organizations, supports or activities that you would like information about or referrals to?** Does the consumer want information or referral to community activities or organizations, support groups? If yes, list and develop a strategy to provide the requested information.
7. **Increasing natural supports?** Offer education about what is a natural support. Who in your life provides you support? How do they support you? Do you want to work towards having more support persons in your life? Begin to identify how the consumer in partnership with the CMH can build natural supports
8. **What type of involvement would you like your family or guardian to have in your planning?** Do you want to invite them to the planning meeting? Do you need any accommodations help your support persons attend the meeting? (Example: time and location of meeting?)
9. **Do you need to develop a crisis plan?** Does the consumer desire a crisis plan? The crisis plan can be done at this time if needed or at the plan of service meeting. Please refer to the **Crisis Plan Worksheet** that can be utilized to develop a crisis plan to be included in the plan of service. Other models such as WRAP and other crisis planning are available. Indicate whether consumers desires a crisis plan with yes or no box. If no, the plan can be added at a later time.
10. **Who/m do you wish to attend your planning meeting?** *How would you like to let people know about the meeting? Do you want any assistance with letting people know about your planning meeting? How can I be helpful?*
11. **Where and when would you like to have your meeting?** Record any discussion about alternative and accommodation of time and place discussed.

12. **Who would you like to facilitate your meeting, and who would you like to record the minutes?** (Note also who is expect to record meeting minutes and to distribute the final plan to the consumer in 15 business days following the meeting.)? Consumer can choose whom to facilitate his or her meeting; Consumer can facilitate meeting himself or herself, a family member, a CMH staff or an external facilitator etc. This is an Opportunity to provided information about external facilitation. External facilitation not available for short-term outpatient, medication only or for persons that are incarcerated.) The consumer may choose any of the participants as the recorder, but the primary case worker has the responsibility to complete the Plan of Service and coordinate the distribution of the Plan within the established time frames.
13. **Are there any topics you do not wish to discuss during the planning meeting?** Record the consumer's responses.

The remainder of the form calls for the Plan of Service meeting date, an acknowledgement by the consumer of the person-centered process being explained. Signature, review and distribution are noted.

#### **D. Plan of Service Forms**

Michigan's Mental Health Code requires that "The responsible mental health agency for each recipient shall ensure that a person-centered planning process be used to develop a written individual plan of services in partnership with the recipient (MHC, 330.1712)."

The Plan of Service summarizes the consumer's treatment needs and goals; their expressed desires, choices, dreams, and personal goals; diagnostic information; needed supports which enable the consumer to live as independently as possible and as a member of his/her community. It establishes time frames for the accomplishment of personal and treatment goals, for the delivery and/or arrangement of needed supports (e.g. staffing, environmental modifications, referrals to specialists) and identifies the types of assistance, which will be authorized to assist the consumer. The Plan of Service may contain a crisis plan for consumers requesting this inclusion. The Plan of Service also establishes and documents the medical necessity and/or therapeutic benefit of services.

Person-Centered Planning means that services and/or supports provided to a consumer will honor that person's preferences, choices and abilities. Person-centered planning works **with** the consumer to help him/her achieve desired goals which are valued, desired, and help the individual achieve as independent a life as possible as a full and active community member.

The Northern Affiliation Plan of Service Documents are divided into sections

**Mandatory:**

Section A – Face Sheet

Section B – Diagnostic Formulation

Section C – Goal Page(s)

Section E – Discharge Planning/Rights for Plan of Service

Section F – Signature Page of Plan of Service

**Optional:**

Section D – Community Supports (for longer-term DD and MI Services)

Crisis Plan Worksheet – Tool to develop Crisis Plan and can be attached.

Alternative Services information Sheet

**Section A: Plan of Service Face Sheet**

**Effective Date:** Under Medicaid and DCH regulations, all services must be delivered pursuant to an individual plan of services developed through a person centered planning process. Also, the plan must be current within one year. The person centered planning process, by definition, must accommodate the desires and needs of the individual being served. The planning process may include multiple meetings with the consumer and his or her family or guardian. This planning leads to a completed plan of service, which must be signed by the consumer. Recently, there has been confusion regarding the effective date of the service plan, and subsequently, the date on which a new plan is required. The Northern Affiliation position on this is as follows: The planning sessions for a plan of service should occur prior to the date a plan is due. Typically, this will be within one month of the effective date of the plan. If, at the request of the consumer or his/her family or guardian, the planning session is held more than one month prior to the effective date of the plan, this should be documented in the record. When the planning session is held within one month prior to the effective date of the plan, the next plan is due one year from the effective date of the plan. For example, a planning session is held on June 11, 2003 to develop a plan with an effective date of July 1, 2003. The next plan must be in place by July 1, 2004. If the planning session is more than one month prior to the effective date, the next plan is due within one year of the planning session. For example, due to a consumer request, a planning session is held on January 13, 2003 to develop a plan with an effective date of March 1, 2003. In this situation, the next plan is due in January 2004.

**Review in \_\_\_Months:** This is the review period frequency established at the Plan of Service and

authorized. It does not refer to the next scheduled Plan of Service meeting date.

**Persons Attending:** List all persons attending the meeting. Worker identifies who served as facilitator.

**Person's Desires, Choices, Dreams and Needs:**

**Person's Desires, Choices, Dreams and Needs:** There are several subheadings under this category. For each heading the worker is to use direct quotes whenever possible to indicate the individual's expressed desire, choice, dream, need. If the individual does express or demonstrate a desire, choice, dream, or need under a specific sub-heading, the worker checks the box to the left of the item numbers. This indicates that there is a desire, choice, dream or need, then a goal/support number may be assigned, the topics to be addressed include:

1. **Family and Social Life:** Does consumer express need for improved family relationships? Marriage counseling? Does consumer want/need assistance in mediating or reestablishing relationships.
2. **Childhood History:** Worker includes information as provided by the consumer or his/her legal guardian, parents that would relate to strengths, needs and potential goal areas particularly for the child and adolescent consumer.
3. **Interpersonal Relationships:** Worker lists consumer concerns, goals in this area. Are there barriers/obstacles that need resolution to form and maintain healthy supportive relationships?
4. **Communication:** Worker notes consumer's abilities, needs, and readiness. Does consumer or his/her support staff need training in sign language, use of specialized communication equipment, evaluation and/or treatment by health care provider to improve language or communication ability? Does consumer use or need an interpreter (sign language or otherwise?)
5. **Employment/Education:** Is the individual employed or seeking employment? What kind of work experience/training does the individual need/want? Does the individual need specialized supports or assistance to find employment? Any special skills or interests? Does the individual attend a day program (workshop, adult activity)? What is the individual's past or present educational experience? What does individual need or want? Reading tutor? Computer lab? GED? College course?
6. **Legal (including guardian):** What type of legal services does the individual use or need? Court related? Guardianship? Power of attorney? Criminal history/probation? Assistance of legal counsel? Knowledge of Recipient Rights?
7. **Health:** What are the individual's health concerns or needs including family planning issues? This is a comprehensive area that includes dietary, eating/feeding guidelines, restrictions, supervision needed. In addition it could include health concerns identified by the physician or nurse during the assessment process as needed interventions or goals. If there is a need for nursing intervention, this should be discussed in the narrative and presented here.

8. **Psychiatric/Behavioral:** Worker summarizes needs, personal goals, symptoms of mental illness, behavioral disturbance or other that may require interventions/medications.
9. **Basic Needs:** Worker summarizes needs for treatment and/or supports for food, clothing, transportation, and living arrangements. Is the individual having these needs adequately met? Identify areas of concern. Does the individual express a desire for more or less services? To learn how to do certain tasks, learn new skills? Does he/she want different types of services or supports provider?
10. **Financial:** What are consumer's needs/goals for financial support, assistance, security, and independence?
11. **Gambling:** If the consumer gambles, does he/she need or want assistance if gambling is affecting financial stability, emotional health, and interpersonal relationships?
12. **Safety:** Does the individual feel safe at home, in the community? Is he/she especially vulnerable to exploitation? Does the individual need specialized supports to increase safety? Can they seek their own emergency assistance?
13. **Abuse/Neglect:** Are there issues that need to be addressed in this area? Does consumer need assistance to prevent victimization or to obtain help in resolving personal difficulties in this area?
14. **Adaptive Equipment Used:** Worker identifies adaptive equipment used/needed by the consumer, wheelchair, hearing aid, walker, etc.
15. **Environmental Modification:** Does consumer need/want modifications to living residence to accommodate personal needs (ramps, barrier-free home design, grab-bars, etc.)?
16. **Spiritual:** Worker notes consumer choice/preference regarding church, synagogue, temple attendance, and involvement in a faith community. Does consumer want/need assistance in participating in their faith community?
17. **Cultural:** Does the individual express desire or interest in cultural activities, participation, organizations, and membership? Does he/she have access? Need assistance with access?
18. **Leisure/Recreation:** Does the individual have hobbies, preferred activities, and leisure skills/opportunities? Is he/she a participant in clubs or community organizations? Does he/she need assistance for access or participation? Is the individual a volunteer?
19. **Alcohol and Other Drug Related Concerns:** Does the individual indicate or demonstrate (via personal demeanor, job loss or family stress due to alcohol or other substance abuse problems, driving convictions) any concerns in this area?
20. **Sexuality Issues:** Identify issues described in the assessment that may relate to needs in the plan to address sexuality issues such as family planning information (see Health)

or concerns regarding safety, vulnerability and other issues.

21. **Additional Consultations Needed:** Identify need for other consultations such as further psychological testing, psychiatric evaluations, etc.
22. **Crisis Plan:** Describe need for crisis plan as identified by the consumer in the pre-planning process that could be referenced to the attached Crisis Plan Worksheet with the essential elements described on the Goal page.
23. **Other:** Worker and individual may use this section to provide information about concerns or issues not otherwise addressed in the previous sections.

**Narrative:** This space is used to describe the above-identified areas of consumer strengths, needs identified and discussed in the Goal formulation and planned strategies. If additional pages are needed they can be added to Face Sheet and identified as Page 2 of 2 using the same footer “Plan of Service Face Sheet.”

**Name of Consumer/Date of Birth/Consumer Agency ID #/Date:** Worker records this information at the bottom of the form.

**Page:** In this section there may be more than one page of the narrative. If so the Page should read “Page 1 of 2 or however many pages make up this section.”

### **Section B: Plan of Service Diagnostic Formulation**

**Diagnostic Formulation:** This is based on the most current clinical information and the DSM-IV. The appropriate category box must be checked. There are two boxes each for Axis I, II, and III for the worker to enter primary and secondary diagnoses within each axis. The worker must then identify which of all of the diagnoses is the “Principle” diagnosis (the current, main focus of treatment/support) and mark that box. **Axis V must include a GAF score, except for individuals with developmental disabilities for who as GAS score is entered instead.**

**Source of Diagnosis:** If the worker completing this form is not credentialed/privileged to diagnose, the source for this information must be clearly identified; name of professional, professional’s licensure/registration, date of source report.

**Summary and Justification of Diagnosis:** If there is a change in the diagnosis from the most recent assessment, the worker provides a summary and justification.

**Name of Consumer/Consumer Agency ID #/Date:** Worker records this information at the bottom of the form.

### **Section C: Plan of Service Goals**

**Goal/Support #:** Each and every goal page must be numbered. The first goal is # 1; the next goal is # 2 and so on. The goal should reflect the consumer’s desired outcome. Examples may include; 1) I would like to feel happy and not depressed, 2) I would like to be able to spend a weekend with my

kids without fighting, 3) some day I would like to have my own car, 4) I want to finish high school. These statements are the consumer and reflect the desired outcome. In some cases these may be quite short-term, or they be long-term and span many PCP documents, depending on the case.

**Start Date:** The date that the goal begins. If an annual re-development, the start date will be the day after the current plan expires. If an addendum, the date services will start based on the addendum. All this of course assumes that the plan will be approved/authorized by third party payers if there are any involved.

**Target Date of Completion:** This is the estimated time frame for completion of the goal.

**List Objectives:** The objective section may contain as many objectives as necessary to achieve progress toward the goal during the duration of the goal. Each objective is identified by an alphabetic identifier i.e., a), b), c), etc. An objective is target to be hit, ground to be covered, a process to be completed that relates to and contributes to the achievement of the goal. For example, the dream of owning a car, as manifest in the goal “I would like to have my own car” may generate objectives during the service period of “a) get a part time job and save one half of my earnings” “b) study for and pass the drivers license examination”. These logical steps along the way reflect the level of skill, risk, and motivation the consumer is comfortable investing at this point in time toward the goal. It will necessarily be different with all consumers, but the process remains the same. Objectives are realistic and meaningful steps leading clearly and eventually toward the achievement of the goal. In all cases the objectives must be measurable. They can be simple numerical items “Wally will take out the garbage without parental prompt twice each week” or subtle “get a part-time job and save one-half of my earnings”. In all instances, the goals, when possible without distorting the consumer’s desire, and the objectives need to be in measurable terms.

**Self:** In respect to each objective (if relevant) the consumer will explain the actions they commit to take in respect to the objectives. Mark each objective with the proper corresponding letter “a) consumer will apply for two jobs per week till employed”. Person is always the consumer. Frequency may be expressed by range, a) study 3 hours per week” or by practice, “works all scheduled shifts”.

**Family and Friends,** if involved, identify the action in respect to the objective, “Objective A: Uncle Buck will give a ride to work as needed”. Person responsible is uncle Buck, and frequency would be “on weekends”. Complete objectives as above.

**Community** represents any faction in the community that can be of support. Clubs, organizations, support groups, neighbors and the like. Complete objectives as above.

**Public Agencies:** Any publicly funded agency, FIS, Social Security, Michigan Works, etc. Complete objectives as above.

**Community Mental Health:** In respect to each objective CMH staff will provide service or support. List each objective by letter, provider by last name (in the case of ACT indicate ACT/Jones indicating that the team will be involved and Jones will take the lead on this objective), service by type (therapy, group, social group, psychiatric, support, skill training etc.), and frequency in a range (0-3 times/month, 0-2 times/week). In no case may “as needed” be used or “prn” as a frequency.

**The following items, that is, “Documentation Instructions” and “Crisis Plan” can be omitted when the goal page simply describes a goal, objectives, natural supports and planned strategies. It is to the discretion of the primary worker to determine the needed elements.**

**Documentation Instructions:** These are the directions for direct support staff (home, day program, clubhouse, etc) who are assisting the individuals in achieving his/her goals and objectives. If a worker has authored a specific step-by-step treatment plan with documentation, the worker may make reference to that document and does not need to copy it into the PCP. The specific treatment plan is attached to the PCP.

The **CRISIS PLAN** section must be completed in all cases where the recognizable risk of a crisis is present. The plan must include what the consumer and clinical staff will do, and if available, what natural supports will provide. If completed on the first goal page it is not necessary to complete the same on all goal pages. Simply line through the section on subsequent goal pages and initial near the line. If there is no need for a Crisis Plan this section can be deleted on the Goal Page. The Crisis Plan Worksheet can be utilized to develop elements of the crisis plan. This is a suggested tool for use in obtaining consumer preferences for support during a crisis.

**Name of Consumer/Consumer Agency ID #/Date:** Worker records this information at the bottom of the form.

**Page:** In this section there may be more than one page of goals. If so the Page should read "Page 1 of 2 or however many pages make up this section of goals.

#### **Section D: Community Supports for Plan of Service (Optional)**

This form is to be used for longer term programs in which consumers receive long term and multiple services such as supports coordination, psychosocial clubhouse, ACT, supported employment, supported living, etc. The purpose of this page is to provide a comprehensive checklist of available supports for consumers. Each CMHSP may want to modify and can modify this optional form to reflect the array of supports that they offer.

**Currently Involved Disciplines/Services:** Specify disciplines involved in the provision of services to the consumers.

**Additional Consultations Needed: (Justify):** Justify the need for other consultations of disciplines not currently involved.

**Natural Supports: (Specify in Goal/Support Formulation) Indicate** type of supports discussed in the Natural Supports and Planned Strategies of the Plan of Service Goal pages.

**Current Supports:** This is a checklist of all the current supports and resources that is part of the Plan of Service.

**Referrals needed for additional supports from outside agencies:** Indicate any needed referrals to obtain supports not in place.

**Name of Consumer/Consumer Agency ID #/Date:** Worker records this information at the bottom of the form.

## **Section E: Discharge Planning/Rights for Plan of Service**

**Additional Consultations Needed:** Check box "yes" or "no" to indicate whether or not a professional consultation is needed. If yes, provide detail of this consultation, who, what, where, when, why, how. Identify the professional discipline.

**Restrictions:** If there are any restrictions placed on the individual's rights, indicate in detail what they are and the reasons.

**Discharge Planning:** Describe the conditions needed for discharge. Check the box next to the appropriate statement of expected time frame for discharge. If the individual is not ready for discharge, the worker must indicate what are the conditions for transition to another level of care or give justification for continuation of current services. If the individual is ready for discharge, the worker will describe the conditions needed for success following discharge. The Discharge/Transfer/Continuity of Care Plan Summary must be written and reviewed with the consumer before discharge/transfer can occur.

**Person-Centered Planning Process:** Place a check in each box indicated after the statement is presented and explained to the consumer.

**Conflict Resolution:** This subsection covers informal and formal conflict resolution and requires an explanation to the consumer and explanation of the rights complaints, grievance procedure and information regarding member services. As with the PCP process checks each item as they are explained.

**Other:** The subsection concerns disclosures and information that should be explained as appropriate to the consumer. The last statement that calls for the initial of the consumer applies to all the checked boxes.

**Current Address, Phone and Primary Care Physician:** This is the place to capture current information on address, phone and the primary care physician as this information changes frequently with longer-term consumers.

**Name of Consumer/Consumer Agency ID #/Date:** Worker records this information at the bottom of the form.

## **Section F: Signature Page for Plan of Service (final section)**

**Included in this Plan of Service:** A checklist to ensure that the mandatory sections are completed prior to consumer and participants' signatures.

**Signatures:** Signatures and dates needed of consumer and other participants. Physician review and approval dependent upon CMHSP's policies and procedures. If guardian is not present, verbal authorization can be documented and witnessed by two individuals. If a letter of authorization is sent, a copy should be attached.

**Indicate your preference:** All consumers must be given a copy of their completed Plan of Service within 15 days of the Plan of Service meeting. This subsection documents whether the plan was given or mailed and the date that this occurred.

**Additional Copies Distribute to:** Note whom else received copies of the plan. Appropriate releases must be obtained.

**Name of Consumer/Consumer Agency ID #/Date:** Worker records this information at the bottom of the form.

## **E. Plan of Service Review Form**

The Plan of Service Review Form is completed at periodic intervals as established in the consumer's Plan of Service. Reviews have traditionally been known as "status reviews" for many CMH programs. Plan of Service reviews, to the extent possible, involves consumer/parent/guardian input as well as the worker's review of progress made towards accomplishment of person-centered goals. and make recommendations regarding the continued medical necessity and/or therapeutic benefit of services. This form also provides a comprehensive method to meet state, federal, and national accreditation standards regarding periodic review of treatment plans. The clinical documentation features of the Plan of Service Review are:

**Review Date:** Worker enters date of review.

**Review Period:** Worker checks the appropriate review period box. Frequency of review is established at the PCP meeting and is recorded in the PCP document.

**Diagnostic Formulation:** Worker checks Axis I, II, and III DSM-IV Diagnostic Code boxes to indicate **most current** diagnosis. If the consumer has more than one Axis I, II, or III diagnosis, the worker indicates the primary (principle) diagnosis by checking the appropriate box in the "Primary " column. The worker must also indicate which of the diagnoses is the **principal diagnosis, the current focus of treatment**. The worker gives a narrative description in the "Diagnosis at Review" column. **If the worker completing this form is not credentialed/privileged to diagnose, the source for this information must be clearly identified; name of professional, professional's licensure/registration, date of source report.** For Axis IV, the worker identifies the Psychological/Environmental Problem(s) identified in the assessment and/or treatment process. For Axis V, the worker enters the consumer's GAF/GAS score from admission, re-administers the GAF/GAS at the review date and enters the new score to document change from the baseline established at admission.

**Overall Progress in Treatment:** The worker assesses consumer progress towards PCP goals since admission or the last Plan of Service Review by checking the appropriate box. The worker must also include a narrative explanation for his/her assessment.

**Goal Specific Progress in Treatment:** The worker enters the specific Goal/Supports from the Plan of Service that is being rated and indicates the status of the Goal at the review date by checking the appropriate box. The worker then writes a brief statement of explanation.

**Change in Plan of Service Required?** The worker checks "yes" or "no." All changes must be followed by a brief narrative explanation. Changes other than those scheduled or anticipated in the Plan of Service must be followed up with completion of a Plan of Service Addendum.

**Reviewed with consumer on:** Indicate the date that the Plan of Service was reviewed with the

consumer. If the review occurred without the consumer present, indicate the reason.

**Consumer Satisfaction:** Based on consumer input, the worker checks one of five boxes ranging from "not very satisfied" to "very satisfied". The worker entering a direct quote from the consumer follows this. If this is not possible because of severe cognitive or communication challenges, then the worker bases this section on direct observation of the consumer's behavior, attempts alternative communication techniques, or talks with consumer's guardian and/or caregivers to gather information to make the best determination about consumer satisfaction.

**Signatures:** Worker signs and dates the form, others sign as applicable.

**Name of Consumer/Consumer Agency ID #/Date:** Worker records this information at the bottom of the form.

## **F. Plan of Service ADDENDUM FORM**

This form is completed when there is a change in the consumer's condition and/or support needs which results in an increase or decrease in type, frequency, and intensity of services. It is also completed when a worker notes a need for an addendum to the Plan of Service in his/her Plan of Service Review. Goals or supports added must meet criteria for medical necessity and/or therapeutic benefit.

**Goal/Support to be Discontinued:** Staff writes goal or support number, goal statement or support description, and effective date of discontinuation.

**Effective Date:** Worker notes date that the goal/support is formally discontinued.

**Statement:** Worker briefly summarizes the reason for goal/support discontinuation.

**Goal/Support to be Added:** Staff writes new goal/support number, goal statement or description. Goals are to be numbered in sequential order. Goal numbers need to be "unduplicated," new numbers must be chosen in sequence. New goal number 3 cannot replace discontinued goal number 3.

**Effective Date:** Worker notes date that the new goal/support goes into effect.

**Target Date of Completion:** This refers to estimated date when objective is expected to be met.

**Priority:** This item is completed at discretion of worker and/or consumer if there is a need or requirement to establish priority.

**Objective:** A letter value is assigned to each objective under a single goal/support statement.

**Objective Statement:** Staff writes a measurable objective statement.

**Natural Supports and Planned Strategies:** How can friends, relatives, and community agencies and resources help accomplish this goal? Identify individuals/groups/agencies in each category, what support they can offer, frequency of contact. The "None" box should be used with caution.

**Self:** What action can the consumer take to help accomplish his goal/her goal?

**Family & Friends:** What kind of assistance can be provided to the consumer from family and friends?

**Community:** What kind of community support is available or can be made available to the consumer?

**Public agencies:** What kind of support might be available to the consumer from public agencies? Family Independence Agency? Social Security Administration? Legal assistance organizations? Public transportation? Michigan Rehabilitation Services? Others?

**CMH:** What services are to be provided by the agency/center to assist individual meet this goal or receive this support?

**Documentation Instructions:** These are the directions for direct support staff (home, day program, clubhouse, etc.) that are providing support and assistance to help the consumer achieve his/her goals and objectives. If a worker has authored a specific step-by-step treatment plan with documentation, the worker may make reference to that document and does not need to copy it into the PCP. The specific treatment plan is attached to the PCP document.

**Signatures:** Signatures and dates needed of consumer and other participants. Physician review and approval dependent upon CMHSP's policies and procedures. If guardian is not present, verbal authorization can be documented and witnessed by two individuals. If a letter of authorization is sent, a copy should be attached.

**Consumer, ID #, Date:** Consumer name, consumer agency ID#, and date of PCP Addendum authorship are noted by the worker.

### **G. Progress/Activity Note:**

The Progress/Activity Note is used by workers to record consumer progress towards PCP goals, activities related to supports identified in the PCP, events in a consumer's life and actions taken by the worker to implement the PCP. The worker uses this to document the continued medical necessity and/or therapeutic benefit of services for the consumer.

1. **Stressors and/or Extraordinary Events:** The worker checks "yes" or "no" to indicate if the consumer has experienced or reported any stressors or extraordinary events. If "yes" is checked, the worker enters a brief descriptive summary. If this information is received via a phone contact, the worker checks that box.
2. **Consumer Indicated Changes:** Worker will check "yes" or "no" box; if "yes," worker records any changes in consumer's medical condition, medications and/or health and safety. Information may come from consumer self-report, worker review of consumer's record, input from other individuals such as guardian, spouse, caregivers, and other health care providers.
3. **Mental Status:** Worker may assess the mental status of the consumer utilizing the matrix provided. Options available within this matrix are:
  - a. If the assessment indicates there has been no significant change from last visit, then worker will indicate by checking the box next to "No significant change from last visit".

- b. If the assessment indicates there has been significant change, then worker will utilize the assessment status indicators of Affect, Mood, Thought Process, Orientation and Behavior
  - c. Within each of these indicators, the worker can determine if the change in status is "Remarkable" or "Unremarkable" by checking the appropriate box.
  - d. If worker determines the status change for a specific indicator is "Unremarkable" then there is no further action required.
  - e. If worker determines the status change for a specific indicator is "Remarkable" then the worker will provide additional narrative under the "Comments" column to document assessed change.
  - f. ***If worker does not perform a mental status review, the "not assessed" box is checked.***
4. **Danger To:** Worker will assess if consumer is a danger to "None," "Self", "Property" or "Others" and check the appropriate box.
  5. **Today's Presenting Issue:** Worker summarizes the current issues presented by the consumer or by the consumer's guardian, caregivers, spouse, family members, others. The worker must determine if the issue is already addressed in the Intake/Annual Assessment or PCP; if not, it may be necessary to complete a PCP Addendum or Intake/Annual Assessment Addendum.
  6. **Goals/Supports Addressed per PCP:** Worker checks applicable boxes and writes goal/support statement.
  7. **For CSMs:** Casemanagers/Supports Coordinators check the appropriate box or boxes that describe the worker's activity on behalf of a consumer.
  8. **Interventions Provided:** Worker enters narrative description of actions/interventions taken to assist the consumer.
  9. **Progress Toward Measurable Desired Outcomes:** Worker may enter brief narrative summary or may indicate N/A (Not Applicable or Not Assessed). .
  10. **Signature:** Worker signs form, must include credentials/title and date.

Worker enters consumer name, consumer agency #ID number, and date at bottom of form.

## H. Intake/Annual Assessment Addendum

This form is used by workers to record new information received, changes in diagnoses, or changes in consumer status or condition that occur between Person-Centered Plans. It is also used to record information received after the initial intake but before the PCP. It can also be completed for consumer re-admissions within one year after discharge. **This form is not to be used to meet annual assessment requirements.**

1. **Status Boxes:** Worker checks the appropriate box to indicate if the form is being used to update the Intake Assessment; to add new information received or to reflect change in consumer's condition or status (e.g., this box would be checked if a guardian has been appointed or removed for a consumer); to indicate if this is a readmission for a consumer who has received services from the agency within the previous 12 months. ***A new PCP is required for consumers being readmitted.***
2. **Presenting Concerns:** Worker checks all of the applicable boxes. Each box checked must have accompanying narrative explanation in section 8.
3. **Risk History:** Worker checks the appropriate box to indicate risk; "suicidal/self-abuse," "substance abuse," "homicidal/violence," "abuse/neglect," "new/other."
4. **Mental Status:** Worker checks this box if a mental status review has been completed and makes brief summary statement.
5. **Diagnosis Change:** Worker checks the applicable DSM-IV boxes if there has been a change in diagnosis.
6. **Source and Credentials of Author of Diagnosis:** If the worker completing this form is not credentialed/privileged to diagnose, the source for this information must be clearly identified; name of professional, professional's licensure/registration, date of source report.
7. **Assessments Completed:** Worker checks the applicable box or boxes for assessments completed.
8. **Update Narrative:** The worker gives narrative explanation for any change noted in the previous sections. There should be a separate heading and narrative for each area of concern.
9. **Summary/Justification for Continued Care:** The worker summarizes the consumer's current care needs. Depending on consumer circumstances and need, a new PCP may need to be held, or a PCP addendum written, with participation and consent of consumer/legal guardian.
10. **Disability Designation:** Worker checks applicable disability designation boxes. Each line must be completed. There may be more than one disability designation, but there must be substantiating diagnoses.
11. **Service Designation:** Worker checks applicable service designation boxes. Each line must be completed. There may be more than one service designation, but there must be substantiating diagnoses.

**Signatures:** The form is signed and dated by the worker, supervisor, and by the Physician (if applicable).

**Consumer Name, ID, and Date:** Full consumer name, agency ID number, and date of completion.

#### **I. Discharge/Transfer/Continuity of Care Plan Summary:**

The Discharge/Transfer/Continuity of Care Plan Summary Form is used by workers for consumer discharges from service, transfers between agency units or programs, and to ensure continuity of

care.

The worker meets and discusses discharge planning with the consumer and his/her guardian, if applicable. The worker also reviews and refers to the Intake/Annual Assessment, PCP, PCP Reviews, PCP Addendums and Progress/Activity Notes as part of discharge/transfer planning process.

**This form only needs to be completed ONCE for transfers between agency units/programs. It should be signed by CMH representatives of both the transferring and receiving unit/programs.**

Below are specific instructions for completion of this form.

1. **Discharge:** Check this box only if form is being utilized to record a full discharge from services at the agency or center.
2. **Transfer:** Check this box only if form is being utilized to record a transfer between agency/center units or programs.
3. **From (Unit/Program):** Worker enters the name of the Unit or Program from which the consumer is being discharged or transferred. If the consumer is being fully discharged from treatment, the worker will write in "From All Services."
4. **To:** Write in the name of the Unit or Program to which the consumer is being transferred.
5. **Admission Date:** Enter the admission date to services if this the form is being utilized as a full discharge from services or enter date the consumer was transferred into the unit or program if the form is being utilized as a transfer from a unit or program only.
6. **Last Service Date:** Enter the date the last service was provided to consumer by the agency provider for both a full discharge from services and transfers between agency units/programs.
7. **Discharge/Transfer Date:** Enter the date of either full discharge from services or date of transfer from one agency unit /program to another agency unit/program.
8. **Presenting Concern(s):** Summarize initial issues/concerns which originally caused the consumer to seek agency or unit/program services.
9. **Services Provided:** For Discharges, the worker checks box for each type of service provided to consumer from the admission date to the date of discharge. For transfers between agency units/programs the worker checks the box for each type of service the consumer received from the transferring unit/program between date of admission to date of transfer.
10. **Outcome Score at Admission:** Worker enters score of the applicable test measure used at admission. If a measure is used other than those listed, the worker enters both the name of the measure and the score.
11. **Outcome Score at Discharge or Transfer:** Worker enters score of the applicable test measure used at discharge or transfer date. If a measure is used other than those listed, the worker enters both the name of the measure and the score.

12. **Goals/Supports Addressed per PCP Plan:** The worker indicates the Goal/Supports number(s) that were addressed during treatment (as per the PCP) and notes specific progress made by checking the appropriate box.
13. **Overall Progress in Treatment:** Worker gives assessment of progress made by the consumer since the admission by checking the appropriate box.
14. **Diagnostic Formulation:** The worker enters **current** Axis I, II, and III DSM-IV diagnoses and code numbers. If the consumer has more than one Axis I diagnosis, indicate the principal diagnosis by checking the appropriate box in the "Primary" column. Provide in the "Diagnosis at Transfer/Discharge" column a narrative description. For Axis IV, identify the Psychological/Environmental Problem(s) identified in the assessment and/or treatment process. For Axis V, enter the consumer's GAF/GAS score from admission and re-administer the GAF/GAS at the review date and enter the new score to document change from the baseline established at admission. **If the worker completing this form is not credentialed/privileged to diagnose, the source for this information must be clearly identified; name of professional, professional's licensure/registration, date of source report.**
15. **Medications:** Enter all of the consumer's prescribed medications at the time of discharge or transfer.
16. **Reasons for Discharge/Transfer:** The worker checks the appropriate box to indicate reasons for discharge/transfer. If "other" is checked, the worker must add a brief narrative statement of explanation.
17. **Condition on Discharge/Transfer:** The worker checks box which best describes the consumer's general condition upon discharge or transfer. The worker must include a brief narrative description. How does consumer's current condition compare to that upon admission?
18. **Reduction in Service:** The worker notes whether or not Reduction in Service/Termination of Service Grievance and Appeals forms have been provided to consumer by checking the appropriate box. If the reduction in service or termination of service notice does not apply in a specific discharge or transfer, the worker checks the "Not Applicable" box. NOTE: Worker must confirm ALL "not applicable" cases with supervisor.
19. **Psychiatric Consultation Completed:** Worker checks box to indicate if consumer receiving psychotropic medication has had a psychiatric consultation completed. Worker checks "not applicable" box if consumer is not receiving psychotropic medications at time of discharge or transfer.
20. **Living Arrangements:** Worker checks the box which describes the consumer's living arrangements at the time of discharge or transfer.
21. **Continuity of Care:** Worker checks the applicable box or boxes under "Transferred/Referred to." For all items checked under this column, the worker must then check boxes for each applicable party under the "Responsible for Continuing Care" column.
22. **Recommendations:** The worker enters a narrative summary of recommendations regarding

continuity of care; this will describe the type and need for any additional or continuing supports.

23. **Consumer Satisfaction:** The worker notes the level of consumer satisfaction with services provided by checking the most appropriate box. The worker includes a direct quote from the consumer that supports the level of satisfaction reported.
24. **Appointment Locations:** The worker indicates location, date, times, phone numbers, etc. for all appointments made for consumer regarding continuity of care needs identified in line 21.
25. **Consumer Refused Referral:** Worker checks this box if consumer refuses referral for further services.
26. **Consumer Given Advance Notice:** Check this box if consumer has been given advance notice. A copy of the advance notice must be kept in the consumer's record.
27. **Consumer Has Received a Copy of Discharge/Transfer/Continuity of Care Plan:** Check this box if the consumer has received a copy of his/her Discharge/Transfer/Continuity of Care Plan. Consumers and their guardians must be provided a copy. Worker includes phone number that consumer can call should he/she want agency assistance after discharge.
28. **Signatures:** Consumer (Parent or Guardian, if applicable) and the applicable staff will sign and date the form. A line is also included for physician signature, if required.