Title: Person Centered Plan (PCP) Procedure

Prepared By: Clinical Director

Purpose:

To define the guidelines and requirements to be used when developing a person/family centered plan of service and the delivery of supports and services in accordance with established state and federal regulations (reference Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program.

Scope:

This procedure applies to all employees (including full-time employees, part-time employees, contractual providers, volunteers, students, and/or interns) of Huron Behavioral Health (HBH) and all consumers served by HBH.

Information:

1. The Michigan Mental Health Code requires that every consumer receives an individualized written plan of services in partnership with the consumer within seven (7) days from the "commencement of service" (330.1712) (see also "Definitions" section for clarification). HBH makes every effort to schedule the first appointment after intake assessment within seven (7) days. However, the Michigan Department of Health and Human Services (MDHHS) allows up to fourteen (14) calendar days for the first follow-up appointment.
2. In accordance with the MDHHS contractual requirements and Person-Centered Plan (PCP) Best Practice Guidelines, the PCP must be delivered to the consumer within fifteen (15) business days of the PCP meeting.
3. The Person Centered Plan (PCP) is to be developed and written with the fullest possible participation of the consumer and their family and/or legal guardian, as appropriate. By definition, the PCP is directed by the consumer, and their parent and/or guardian. The consumer must sign his/her PCP. If the consumer has a guardian, the guardian will also sign the PCP (see also "Personal Representative/Guardian Policy" ORI.1.15).
4. HBH will assist the consumer and their advocates to design services which are based on medical necessity and are the least restrictive/intrusive services available.
5. Some consumers served by HBH do not have a range of life experiences to be able to make fully informed decisions. Because of this, it is essential for HBH staff to:
   a. Assist the consumer to gain the experience and skills needed to make informed decisions
   b. Explain (in ways that the consumer and their natural supports can clearly understand):
      - The available options/service alternatives
      - The benefits, consequences, and risks of those options
      - The ways HBH can (and cannot) support the achievement of their desired outcomes
6. The PCP is the foundation for all treatment activities and becomes the prescription for services. Therefore, treatment cannot be effectively or efficaciously provided until mutually agreed upon goals and service needs are defined. The Person Centered Plan consists of many aspects, which include, but may not be limited to:
   - Identifying the medically necessary services (Scope, Duration, Frequency, Intensity)
   - Identifying any co-occurring treatment needs
   - Defining goals, objectives, methodology, and the timeframes for completing them
   - Developing social inclusion activities and community involvement
   - Assisting with meaningful and competitive employment opportunities
   - Identifying the consumer's natural supports/family relationships and informal social networks
   - Identifying and addressing the consumer's health and safety concerns
   - Identifying the consumer's strengths and skills
   - Identifying the consumer's cultural & ethnic Issues
   - Identifying any assistive technology/LEP (Limited English Proficiency) needs

- Identifying any unmet service and supports needs
- Defining the review frequency (Periodic Reviews)

7. Huron Behavioral Health views the Person Centered Plan as the individual's treatment plan. When the HBH physician is involved in the consumer's treatment, the HBH physician will also sign the PCP. Additionally, using the PCP Form in the Electronic Medical Record (EMR) system, the PCP must specify all services with the exception of those not requiring an authorization (i.e. Emergency Services and Initial Assessment). Each service that requires an authorization must show how and by whom they are to be provided, as well as the amount, scope, frequency, and expected duration of each service to be provided; as well as the desired outcomes.
8. Clinical Assessment findings should form the basis for goals defined in the PCP and must be strength-based and include agreed upon goals, desired outcomes, and timeframes for achieving them. The PCP must also incorporate recommendations from the pre-plan, clinical assessments, safety checklists, and initial health screens. As applicable, these must be completed prior to the PCP meeting so that the recommendations are incorporated into the PCP as goals, objectives, and team assignments, etc,
9. It is the policy of HBH to have only one (1) active PCP for any consumer served. If additional services are added or changed after a PCP is developed, a new PCP or an addendum may be used to convey the additions/changes to the plan (see PCP Addendum Procedure QI.2.23).
10. The Person Centered Planning process also reflects when a behavior treatment plan needs to be developed as part of the treatment plan (see also "Behavior Treatment Plan Policy" BM.1.01).
11. Family-centered and youth-guided planning, supports, and services are provided for minor children.
12. Consumers are provided with ongoing opportunities to express their needs, desires, preferences, and meaningful choices.
13. Individuals are provided with ongoing opportunities to provide feedback relative to the services, supports, and treatment they are receiving from HBH (i.e. during the Periodic Review and the program-specific consumer satisfaction survey process).
14. In accordance with regional/affiliation agreement and standardized practices. If a guardian cannot attend the consumer's PCP meeting and is not available to sign the initial PCP, it is understood that "implied consent" has been granted to the consumer to sign/approve the PCP (see "Definitions" section).
15. Any persons providing direct care services in conjunction with a planned service (as directed in the individuals' PCP) will receive PCP-specific training regarding the individual's needs must sign a "PCP-Specific Training and Agreement Form for Personal Care Staff" (90-004) to indicate they understand will abide by the individual's PCP/individual plan of service.

Procedure:

A. PCP Rules:

1. Before services can be provided by HBH, a PCP must be completed (except for Emergency Services (ES)/crisis interventions and Initial Assessments).
2. The Michigan Mental Code requires that every consumer be given PCP pre-planning (see "PCP Pre-Planning Procedure" QI.2.34).
3. A PCP must be started well enough in advance of the current PCP's expiration date so that the subsequent PCP is completed before the expiration date of the current PCP, so that services are continuous and uninterrupted. Workers are expected to begin the PCP process at the third Periodic Review to assure adequate time to complete the new PCP without any lapse in the plan and services).
4. PCPs can be written for up to one (1) year but cannot exceed a one (1) year period.
5. PCPs must list every service that is provided (except for Emergency Services and Initial Assessments).
6. PCPs must be addended or re-written if the consumer's treatment needs change.
7. If HBH is billing for a service, it must be:

- Medically necessary
- Stated in the PCP *(Note: Exceptions include Emergency Services and Initial Assessments)*
- Provided to the individual at the frequency, scope, & duration stated in the PCP
- Accurately documented in the consumer's case record

8. Services defined in the PCP must be medically necessary and must be stated in terms that align with the service terminology utilized in the Medicaid Provider Manual. All services to be provided (including all ancillary services must be included in the services section of the PCP. Decisions to deny or authorize service in amount, scope, duration that is less than requested are made by a health care professional with the appropriate clinical expertise in treating the individual's condition. In addition to defining the services in the PCP, the worker must include the unit cost for services to provide a "Cost of Service Report" as part of the PCP.

9. Services must be defined in the PCP with amount, scope, and duration (see guidelines in the table below):

Service	Amount	Scope	Duration	Level of Need/ Medical Necessity
Medication Reviews	1-3 Times	Quarterly	1 year	per Psychiatrist direction
Outpatient Therapy	2-4 sessions	Monthly	6-12 months	Locus Level 1 or 2 (complete Initially, when the Level of Care changes, quarterly, at the end of services, at the time of the PCP)
Group Therapy	1 time	Weekly	Length of Group Therapy	Locus Level 1 or 2 (complete Initially, when the Level of Care changes, quarterly, at the end of services, at the time of the PCP)
Case Management/ Supports Coordination	1-2 times	Monthly	1 year	Locus Level 1 or 2 (complete Initially, when the Level of Care changes, quarterly, at the end of services, at the time of the PCP)
Intensive Case Management	1 time	Weekly	1 year	Locus Level 3 or higher (complete Initially, when the Level of Care changes, quarterly, at the end of services, at the time of the PCP)
Home Based / Infant Mental Health	4 hours	Weekly	6-12 months	PECFAS or CAFAS score of 80 or higher; or if there is a score of 20 or higher in both 'Self Harm' and 'Behavior Toward Others' categories (complete Initially, quarterly, at end of services)
Assertive Community Treatment (ACT)	2-5 times	Weekly	1 year	Locus Level of 4 or higher (complete Initially, when the Level of Care changes, quarterly, at the end of services, at the time of the PCP)
Skill Building Assistance	11-22 units	Weekly	1 year	PCP and Assessment of Need (90-573)
Supported Employment	22-66 units	Weekly	1 year	PCP and Assessment of Need (90-573)
Respite Care	As determined by Respite Rating Scale (90-547)			Respite Needs Assessment Form (90-547)
Community Living Supports	8-60 units	Weekly	1 year	PCP and Assessment of Need
Specialized Residential	Daily rate after assessed rating (10-008 or 10-009)			Specialized Residential Rating Scale Form (10-008 or 10-009)

10. It may be determined during the PCP meeting that an individual meet the medical necessity criteria for OT and/or PT services and these services will be included in the PCP. If it is determined after the PCP meeting that OT and/or PT services are medically necessary the PCP will be addended. (Note per Medicaid

guidelines, a physician must prescribe these services.) If the consumer is receiving nursing services, the Registered Nurse (RN) will contact the physician's office and ask for an order for the OT and/or PT service(s). If a consumer is not under a program nursing service, the primary worker will obtain an order from the primary care provider. A copy of the order is to be retained in the consumer's case record.

11. Services provided to the consumer must be in accordance with the frequency, scope, and duration agreed upon in the PCP. If the consumer is being under-served (i.e. receiving fewer services than the defined frequency in the plan) or over-served (i.e. receiving more frequent services than defined in the plan), the PCP must be addended. (See also PCP Addendum Procedure" QI.2.23). If under-served, the consumer must also be given Advance Notice in accordance with the HBH "Appeals and Grievance Procedure" (RR.2.36) as this is a reduction in services from what was agreed upon in the plan. Additionally, the PCP provides the consumer with available conflict resolution options and information.

12. Any services listed in the PCP must have supporting goals, objectives, and/or team assignments to evidence the need for the service being provided by HBH.

    - Whenever primary services are prescribed in the PCP, the worker must develop supporting goals and/or objectives (primary services include services such as targeted case management, supports coordination, home-based, assertive community treatment, medication clinic services, outpatient therapy, etc.).
    - Whenever ancillary services are prescribed in the PCP, the worker must develop supporting goals, objectives, and/or team member assignments in the PCP (ancillary services include services such as skill building, supported employment, community living supports, respite, peer support specialist services, etc.).

13. Services are not to be provided to the consumer unless there is a current PCP or Addendum to the plan (except for Emergency Services and Initial Assessments). While it is the primary worker's responsibility to have a valid/current PCP in place for each consumer served, all HBH programs are required to continuously monitor to assure that there is a current/valid PCP and to be continually monitoring for a lapsed PCP. Staff is to immediately notify their supervisor and the primary worker when the PCP has lapsed and there is not a current PCP in EMR.

14. Program Managers must continuously monitor the status of the PCPs for the consumers being served in their program to assure that they are not violating Medicaid Provider Manual guidelines

15. If service delivery cannot occur in accordance with the consumer's PCP for circumstances that are beyond the worker and/or consumer's control (for example the consumer has been hospitalized, jailed, or has traveled out of state, etc.), the following guidelines shall be used by staff:

    a. If a consumer is hospitalized, in jail, or out-of-area for up to one (1) month, it is not necessary to addend the PCP or generate an Advance Notice, since the situation is short-term/temporary. However, the worker must document the situation in progress notes explaining why planned routine visits were not conducted.

    b. If the length of time in the hospital, jail, or out-of-area exceeds one (1) month in duration, the consumer should be sent an Advance Notice identifying the suspension of services in accordance with the "Appeals and Grievance Procedure" (RR.2.36) and the PCP should be addended in accordance with the "PCP Addendum Procedure" (QI.2.23).

    If the above steps are not met, it also creates a Recipient Rights violation which requires staff to formalize a Recipient Rights Complaint and the HBH Recipient Rights Officer to conduct a formal rights investigation.

    c. If a consumer has not been active or engaged in treatment for more than one (1) month, and an Advance Notice has been sent with no response from the consumer, the worker will generate an administrative addendum to close out authorizations, goals, and objective in the EMR. Since the addendum is administrative in nature, the addendum does not need to be sent to the consumer/guardian, but is an EMR systems requirement/record only.

16. HBH staff who do not comply with the requirements for PCP, are subject to disciplinary action, up to and including termination depending upon the severity of the violations.

B. PCPs for New Consumers in a Stable State:

1. The Primary Worker is responsible for completing the Pre-plan and the PCP with the consumer (see flowchart page 6).
2. In accordance with the Michigan Mental Health Code, it is the goal of HBH to complete a PCP for every consumer served within seven (7) days of the commencement of services utilizing the PCP form. Note: For the purpose of this procedure, "commencement of services" will be defined as the Initial Intake Assessment for all Programs except OBRA. For the OBRA program, "commencement of services" shall be the date that HBH receives the signed consent form after the MDHHS letter of determination approved eligibility for mental health services). However, since the consumer determines their preference for when the PCP meeting will be held, this may not always be feasible. In these situations, a Progress Note shall document the consumer's reason for the delay in completing the PCP (note: staff reasons for delaying a PCP are not allowable). In all cases, a PCP must be completed within thirty (30) days of the start of services, unless the consumer is clinically incapable or in an unstable state and cannot participate in a PCP meeting. In these cases, the exception will be clearly documented by the worker in progress notes as to why the PCP could not be completed.
3. In accordance with MDHHS guidelines, the PCP must be delivered to the consumer within fifteen (15) business days of the PCP meeting (see "Definition" section below), along with the Fair Hearing Information (for Medicaid and Non-Medicaid consumers).

C. PCPs for New Consumers in an Acute Psychotic State:

1. At the first visit, the Primary Worker will complete an Initial/Intake Assessment utilizing the Clinical Assessment Form in EMR.
2. While in an acute psychotic state, documentation will be generated for the case record that identifies the short-term treatment activities and services provided. This may be accomplished through progress notes, evaluations, additional assessments, etc., which will also include the reasons that the PCP is being delayed.
3. In these cases, an "Initial Assessment & Plan Form" (90-164) should be completed which serves as a temporary treatment plan until the consumer is stable and can develop his/her PCP. As soon as the consumer is stable and is capable of participating in a PCP meeting, a Pre-Plan and PCP will be developed.

D. PCPs for Current Consumers / On-going Services (see flowchart on page 6):

1. The Primary Worker is responsible for completing and maintaining a current PCP at all times. There can be no lapses in PCP and no delinquent PCPs.
2. The PCP must be updated at least annually (or more often if there are significant changes in status, goals, or needs, or if the consumer requests a new PCP).
3. Well in advance of the expiration of the PCP (typically at the third Periodic review), the primary worker will complete a Pre-plan with the consumer and schedule a PCP meeting date, such that the current PCP does not expire before a new one is completed.
4. The PCP must be completed by the primary worker and forwarded to the Unit Manager within seven (7) calendar days of the PCP meeting.
5. The PCP must be given to the consumer within fifteen (15) business days (see "Definition" section below) of the PCP meeting.

E. PCP Requirements for Transfers and Referrals to Other HBH Services:

1. When a consumer is receiving multiple services, the more intensive service will be responsible for developing the PCP. Levels of intensity are shown in examples below, ranked from most intensive to least intensive:

MOST Intensive ↓ LEAST Intensive	Assertive Community Treatment (ACT) / Home-Base Services Intensive Case Management Case Management / Supports Coordination (CSM/SC) Out-Patient Therapy (OP) Dr. Services only (Medication Reviews only)

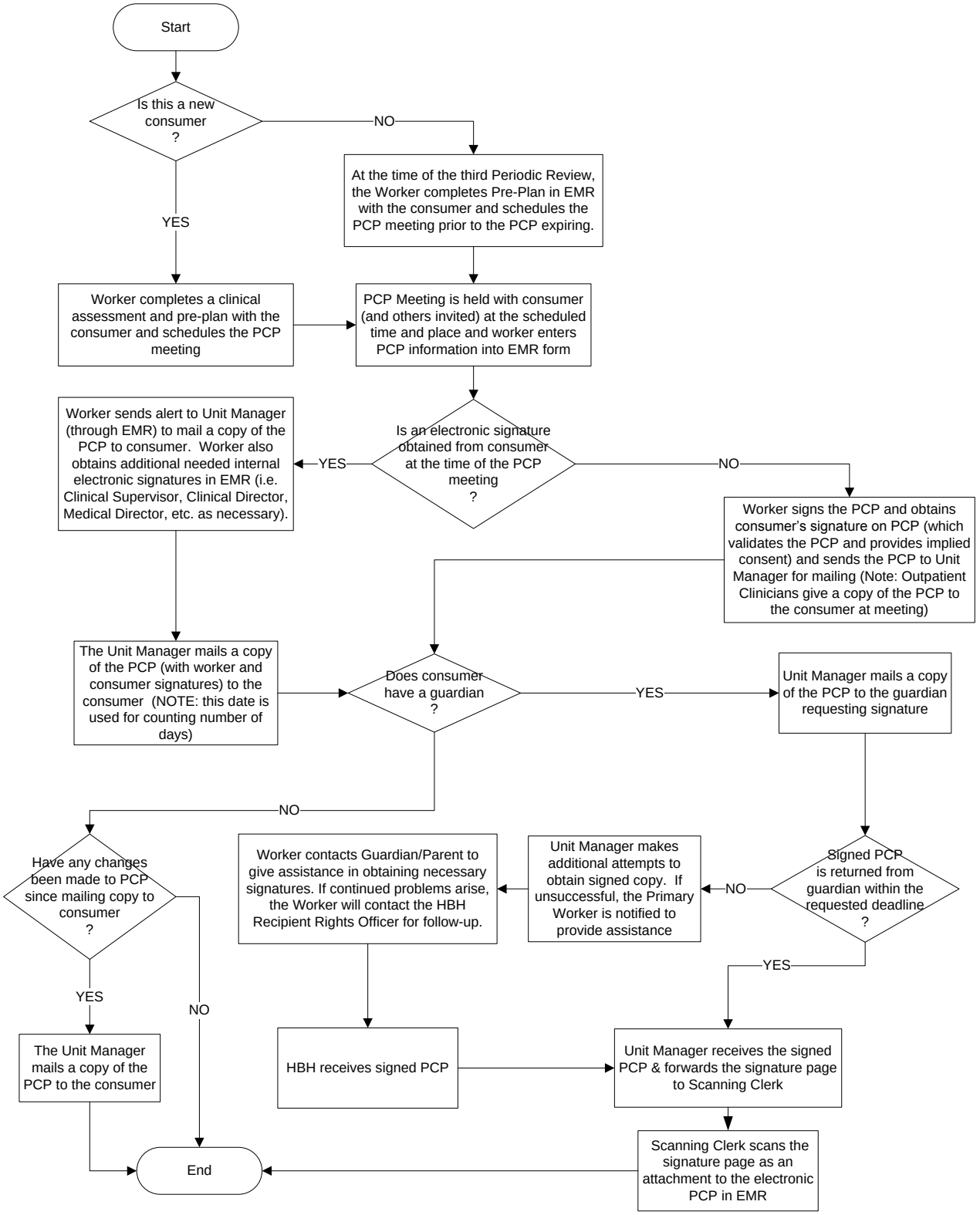
2. If a consumer is transferred to an additional service or from one service to another, the following guidelines will be used to determine what is needed for a treatment plan/PCP:

   - **Added Service** that is LESS intensive than the initial service (for example adding Outpatient Therapy when the consumer is already receiving ACT services), an addendum will be completed to supplement the PCP. The addendum will identify the services, goals, team assignments that are being added/changed. New goal(s) an be addended into the PCP which was completed by the more intensive service provider.
   - **Added Service** that is MORE intensive than the initial service (for example adding CSM services when the consumer is already receiving Out-Patient Therapy), a full PCP will be developed by the more intensive service program which then replaces any previous PCPs.
   - **Transfer of Services:** (i.e. closing out one service and replacing it with another service) If the consumer is transferred from one service to another, a new PCP must be developed within thirty (30) days of the transfer. For example, when a consumer is transferred from Case Management to ACT, a new PCP must be done; an addendum is not acceptable.

F. Consumer Refusal to Participate in a PCP:

1. On rare occasions, a consumer may refuse to participate in a PCP meeting. If the treatment team determines that the consumer needs to continue treatment regardless of their willingness to develop a person-centered plan, the treatment team will develop a treatment plan including clinical treatment goals based upon their knowledge of the individual's needs and desired outcomes. The goals will be monitored through progress notes. After the treatment plan is developed, the plan will be presented to the consumer for signature. If the consumer refuses to co-sign the plan, the primary worker will write "Refused to Sign" on the consumer's signature line. A copy of the plan will be given to the consumer within fifteen (15) business days of signing.
2. The primary worker must continue to encourage the consumer to develop a PCP, and, as soon as he/she is willing to participate in a PCP meeting, a pre-plan and PCP is to be developed with the consumer's input. The worker's efforts to encourage the development of a PCP and the consumer's responses must be clearly documented in progress notes.

G. PCP Flowchart:
(see page 7)


Start
Is this a new consumer ?
NO
YES
At the time of the third Periodic Review, the Worker completes Pre-Plan in EMR with the consumer and schedules the PCP meeting prior to the PCP expiring.
Worker completes a clinical assessment and pre-plan with the consumer and schedules the PCP meeting
PCP Meeting is held with consumer (and others invited) at the scheduled time and place and worker enters PCP information into EMR form
Is an electronic signature obtained from consumer at the time of the PCP meeting ?
YES
NO
Worker sends alert to Unit Manager (through EMR) to mail a copy of the PCP to consumer. Worker also obtains additional needed internal electronic signatures in EMR (i.e. Clinical Supervisor, Clinical Director, Medical Director, etc. as necessary).
Worker signs the PCP and obtains consumer's signature on PCP (which validates the PCP and provides implied consent) and sends the PCP to Unit Manager for mailing (Note: Outpatient Clinicians give a copy of the PCP to the consumer at meeting)
The Unit Manager mails a copy of the PCP (with worker and consumer signatures) to the consumer (NOTE: this date is used for counting number of days)
Does consumer have a guardian ?
YES
Unit Manager mails a copy of the PCP to the guardian requesting signature
NO
Signed PCP is returned from guardian within the requested deadline ?
NO
Unit Manager makes additional attempts to obtain signed copy. If unsuccessful, the Primary Worker is notified to provide assistance
Worker contacts Guardian/Parent to give assistance in obtaining necessary signatures. If continued problems arise, the Worker will contact the HBH Recipient Rights Officer for follow-up.
Have any changes been made to PCP since mailing copy to consumer ?
YES
NO
The Unit Manager mails a copy of the PCP to the consumer
HBH receives signed PCP
Unit Manager receives the signed PCP & forwards the signature page to Scanning Clerk
Scanning Clerk scans the signature page as an attachment to the electronic PCP in EMR
End

H. PCP Addendums:

1. An addendum may be written to supplement/modify a PCP for various situations:
   - The consumer's goals have changed or new goals have been added
   - A Behavior Plan is needed to address behavioral issues
   - Team Assignments have changed or been added
   - Additional services have been added which require additional goals.
   - Health and/or safety concerns have been identified
2. When an addendum is needed, the worker will generate the addendum in the EMR system and provide a reason for the addendum. The primary worker will obtain the necessary support information and appropriate signatures. When a supplemental addendum is developed it remains active until the next full PCP is completed.
3. PCP Addendums are considered a supplement to the PCP and therefore must follow the same guidelines as defined contractually and by the Michigan Mental Health Code in that addendums must be delivered to the consumer within fifteen (15) business days of the addendum.

Definitions/Acronyms:

Definitions:

"Given to the consumer within Fifteen (15) Business Days" – In conjunction with the regional/affiliate board practices, HBH has adopted the practice of counting the business days from the time the PCP is given to the consumer. A copy of the PCP may be given with the consumer and worker signatures only. (If changes are made to the PCP during the supervisor and/or clinical director sign-off, an updated copy must be given to the consumer reflecting the changes made). If the consumer has a guardian, counting the days can begin from the date the PCP is mailed to the guardian. The PCP may be mailed with signatures of the consumer, worker, supervisor, and clinical director. The PCP need not be held for Guardian and Psychiatrist signatures before counting the days.

"Commencement of Services" – For the purpose of this procedure, start of services will be the point of the Initial Intake Assessment.

"Implied Consent" – refers to the understanding given between the guardian and worker when the guardian has been invited to the PCP meeting, but cannot/does not attend and the consumer signs their own PCP which is considered a valid PCP for the purposes of providing the PCP to the consumer within the required fifteen (15) business days.

Acronyms:

ACT – Assertive Community Treatment
COA – Council On Accreditation
CSM/SC – Case Management/Supports Coordination
EMR – Electronic Medical Record
HBH – Huron Behavioral Health
MDHHS – Michigan Department of Health and Human Services
OBRA – Omnibus Budget Reconciliation Act
OP – Out-Patient
PCP – Person Centered Plan

Forms:

90-004 PCP-Specific Training and Agreement Form for Personal Care Staff
90-164 Initial Assessment & Plan Form
Clinical Assessment Form (in EMR)
Person Centered Plan (PCP) (in EMR)
Pre-Plan Form (in EMR)
PCP Addendum Form (in EMR)

Records:

PCPs are retained in the consumers' case record in accordance with the HBH Record Retention and Storage Policy (QI.1.23).

Reference(s) and/or Legal Authority

COA standards
MDHHS PCP Best Practice Guidelines @ http://www.michigan.gov/mdhhs/
Michigan Mental Health Code 330.1712
Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program
BM.1.01 Behavior Treatment Plan Policy
ORI.1.15 Personal Representative/Guardian Policy
QI.1.05 PCP Policy
QI.2.23 PCP Addendum Procedure
QI.2.34 Pre-Planning Requirements for Person Centered Planning Procedure
QI.1.23 HBH Record Retention and Storage Policy

Change History:

Change Letter	Date of Change(s)	Changes
A	08/26/04	Changed "15 days" to "15 business days" several places, added the second sentence in the "Information" section item # 7, Under "Information" #1, added Children's Services to 90-028 and removed Substance Abuse, added Substance Abuse to 30-007 & 30-002
B	01/10/05	Added # 1, 2, 6, 7 & 8 in "Information" section to comply to G8 requirements
C	01/26/05	Added to "Information section: second sentence in #1, #3, #4, & #5, added Acronym "AAM", changed "G8" reference to "G8.4 & G8.6"
D	04/25/06	Added #1 & #5 in "Information" section, in #9, changed "changes" to "additions", added references to the Mental Health Code & PCP Addendum Procedure (QI.2.23), removed from #17 "At a minimum, a PCP Addendum will be completed and appropriate goal pages and/or team assignment pages will accompany the addendum", added A.3, added section "D" (Transferring consumers), and added section "E" (Consumers Refusing to Participate in PCP)added C.2, C.3, & C.4 . to better clarify current practices, changed bullets to numbers, corrected formatting & grammar, re-worded sentences without changing sentence content.
E	05/08/06	Added the OBRA start of services sentence in A.2. to clarify PCP requirements in this program.
F	08/14/06	Added the note in D.2 to clarify goals and addendums
G	09/11/07	Revised to include new regional PCP form (90-1003) and Pre-Plan (90-1004), re-ordered bullets in #3 under "Information" section and added second bullet, Reworded B.1 to reflect use of new Intake Form, in C.2 – added "or if a consumer requests….", reworded first bullet in D.2 to reflect new regional addendum form (90-1005), added new regional form numbers to "Forms" section and deleted corresponding obsoleted HBH forms, added hyperlinks, Removed references to PCP Instructions (QI.3.01 & QI.3.02) as these are being obsoleted with the new regional forms and electronic medical records systems
H	01/05/09	"Information" section : reworded #4 in "Information" section to remove physician signature on all PCP (only needed when physician is directly involved with the treatment and then split #4 into #4 & #5, item #10 – removed list of available forms, in "Forms" section – removed 90-347 (GF PCP Form) & 70-001 (OBRA/Geri PCP Form)
I	02/04/09	Reviewed and revised to comply with COA 8th Edition Standards and present practices – removed COA chapter-specific reference (G.8.4 & G.8.5), added 10th bullet and also "and skills" to 7th bullet Information section #3 and also to 10.a, reworded 2nd sentence in #5 (Information section),added last sentence #7 (Information section), added last 2 sentences #2 (Information section), changed "Title X" to "Medication Reviews" in D.1. added to 5th bullet #3 (Information section) "/family relationships and informal social networks.".
J	01/14/10	In A.3, C.6, and E.1, added "(see definition section below)", added "15 Business days" to "Definition" section
K	01/12/11	In "Information" section Added #2, removed "Gallery" from "Records" section, removed 2nd sentence in F.5 which spelled out requirements for paper-copies of PCPs, added A.1 – A.15 in "Procedure" section to clarify requirements and current expectations, added flowchart for clarification, reworded and reformatted numerous sentences without changing content.
L	03/07/11	Added second sentence in #1 in "Information" section, added last sentence in #8 in "Information" section, Removed section "F. PCP Process" as this was replaced with flowchart on 01/12/11, corrected numerous typographical errors, formatting errors, and references, added hyperlinks, changed "start of service" to "commencement of service" throughout document to be consistent, , reworded A.7 to comply with Clinical Director's memo dated 03/03/11, added "jail" to 13.a & 13.b, changed "Adequate Notice" to "Advance Notice" throughout document to correct in accordance with RR.2.36 "Appeals and Grievance Procedure",
M	03/22/11	Reworded OBRA "commencement of services" (3rd sentence in B.2) to comply with process and OBRA criteria in, added 2nd and 3rd sentences in the "Definitions" section under "Given to the consumer within 15 days" to match regional PI practices learned 03/17/11.
N	05/11/11	Added last sentence in A.15, added #10, #11, #12, & #13 in "Information" section,
O	11/07/11	Added statement below #9 to comply with MDCH/AAM requirements. Corrected the numbering in Procedure A., in "Information" section #8 changed wording to reflect recent changes in health screen administration (now initial only) & removed "With the exception of the initial PCP", reworded several sentences throughout document without, changing sentence content, in "Records" sections removed "Effective 10/01/07, PCPs will be retained electronically using the EMR (Electronic Medical Record) system." Added 100-028 in "Forms" section.
P	10/10/13	In "Information" section added 5th bullet in #6, and "the pre-plan" in #8, in "Procedure" section A.3 added "of the current PCP", "Begin the PCP process", & "and services", added A.11, added hyperlinks, removed 100-028 Cost of Service Report from "Forms" section, made numerous small grammatical edits/corrections without changing sentence content. Removed Section A #7and #11 removed "and valid" after current in the first sentence.

Change Letter	Date of Change(s)	Changes
Q	04/29/14	Removed reference to "regional" and "standardized regional forms" and "AAM" throughout document (5 places), removed "AAM" and "SA" from "Acronym" section, in "Forms" section removed "90-1002", "90-1003", "90-1004", and "90-1005" and added "(in EMR") 4 places, in "Definitions" section added "Implied Consent", removed "Services" table/example in A.8, removed "Medicaid & All consumers" table/examples in B.3, in table in E.1 added "Intensive Case Management", modified "G. PCP Flowchart" to reflect present process/practices since implementing HBH's new EMR system (HERBI), made numerous additional small grammatical and typographical correction throughout document without changing sentence content, added #14 in "Information" section, added #11 in "Procedure" section.
R	06/25/14	In "Information" section #7 added "with the exception of…." And the last sentence, in A.5 added "Medication Administration, Medication Training and Support, and Initial Assessments", second bullet in A.7 and A.12 added "Medication Administration, Medication Training and Support", added A.14.c, modified flowchart to reflect recent process changes.
S	09/30/14	Added "Amount, Scope, Duration, & Level of Need" Table in #9, added 3rd sentence in #8.
T	04/08/15	In "Information" section #11 added "and youth-guided planning,"
U	08/26/15	In table in A.9 added frequencies of LOCUS & CAFAS (6 places), added #15 in "Information" section.
V	10/07/15	Removed item D.4 which stated "If the new PCP is not completed prior to the current PCP's expiration date, an addendum must be generated to cover any lapsed periods of time. Addendums used as an extension cannot exceed thirty (30) days in duration. There can be no more than one (1) extension unless approved/signed by the Clinical Director." As the new EMR system prevents this from happening.
W	01/26/16	Added A.10
X	02/18/16	Added section "H. PCP Addendums" and reworded "Purpose" section to include reference to 1915 waiver program and attachment P.4.4.1.1.
Y	07/26/17	Changed "Michigan Department of Human Services/MDCH" to Michigan Department of Health and Human Services/MDHHS" throughout document (6 places), removed several "exceptions" for authorizations & PCP to remove services (Plan Development meeting, inpatient hospitalization, medication administration,, Medication training and support) (5 places) as these services are now required to have authorizations, removed reference to "attachment P.4.4.1.1" (2 places).