Detroit-Wayne County Community Mental Health
Person Family Youth Centered Plan
DRAFT

PROVIDER NAME: (text box)	MCPN: (text box)
DEMOGRAPHIC INFORMATION	
Consumer Name: (text box)	MHWIN ID: (text box)
Agency ID: (text box)	Date: (text box)
Facilitator: (text box)	Location: (text box)
Attendees: (text box) Birth Date	

PERSON FAMILY YOUTH CENTERED PLAN			
Type of Review	☐ Initial	☐ Annual	☐ Review
SNAP			
Strengths:	(text box in consumers, parent/guardian, families words)		
Needs:	(text box in consumers, parent/guardian, families words)		
Abilities:	(text box in consumers, parent/guardian, families words)		
Preferences:	(text box in consumers, parent/guardian, families words)		

DREAMS/HOPES	
Consumer:	(text box in consumers words)
Family/Guardian:	(text box in parent/guardian/families words)
Allies: Circle of support	(text box in allies words)
CHALLENGES	
Consumer:	(text box in consumers words)
Family/Guardian:	(text box in parent/guardian/families words)
Allies: Circle of support	(text box in allies words)

LIFE DOMAINS			
Community Inclusion	☐ Yes	☐ No	(Text Box- If yes is selected please provide supporting detail, this will pre-populate a goal statement)
Education	☐ Yes	☐ No	(Text Box- If yes is selected please provide supporting detail, this will pre-populate a goal statement)
Emotional	☐ Yes	☐ No	(Text Box- If yes is selected please provide supporting detail, this will pre-populate a goal statement)

Family	☐ Yes	☐ No	(Text Box- If yes is selected please provide supporting detail, this will pre-populate a goal statement)
Financial	☐ Yes	☐ No	(Text Box- If yes is selected please provide supporting detail, this will pre-populate a goal statement)
Housing/Placement	☐ Yes	☐ No	(Text Box- If yes is selected please provide supporting detail, this will pre-populate a goal statement)
Legal	☐ Yes	☐ No	(Text Box- If yes is selected please provide supporting detail, this will pre-populate a goal statement)
Meaningful Activities	☐ Yes	☐ No	(Text Box- If yes is selected please provide supporting detail, this will pre-populate a goal statement)
Natural Supports	☐ Yes	☐ No	(Text Box- If yes is selected please provide supporting detail, this will pre-populate a goal statement)
Physical Health	☐ Yes	☐ No	(Text Box- If yes is selected please provide supporting detail, this will pre-populate a goal statement)
Social relationships	☐ Yes	☐ No	(Text Box- If yes is selected please provide supporting detail, this will pre-populate a goal statement)
Spiritual Opportunities	☐ Yes	☐ No	(Text Box- If yes is selected please provide supporting detail, this will pre-populate a goal statement)
Transportation	☐ Yes	☐ No	(Text Box- If yes is selected please provide supporting detail, this will pre-populate a goal statement)
Work/Skill	☐ Yes	☐ No	(Text Box- If yes is selected please provide supporting detail, this will pre-populate a goal statement)

HEALTH AND SAFETY			
Guardianship or Alternative or Authorized Representative	☐ Yes	☐ No	(Text Box- If yes is selected please provide supporting detail, this will pre-populate a goal statement)
At Risk Behavior (Please prioritize in goal)	☐ Yes	☐ No	(Text Box- If yes is selected please provide supporting detail, this will pre-populate a goal statement)
Co-Occurring Disorder	☐ Yes	☐ No	(Text Box- If yes is selected please provide supporting detail, this will pre-populate a goal statement)
Crisis Plan Offered	☐ Yes	☐ No	(Text Box- If yes is selected please provide supporting detail, this will pre-populate a goal statement)
Environmental Safety	☐ Yes	☐ No	(Text Box- If yes is selected please provide supporting detail, this will pre-populate a goal statement)
Behavioral Treatment Plan	☐ Yes	☐ No	(Text Box- If yes is selected please provide supporting detail, this will pre-populate a goal statement)

Home Based Service	☐	☐	(Text Box- If yes is selected please provide supporting detail, this will pre-populate a goal statement)
Other	☐ Yes	☐ No	(Text Box- If yes is selected please provide supporting detail, this will pre-populate a goal statement)

INDIVIDUALIZED PLAN OF SERVICE

GOALS					
Goal#	(text box)				
Goal Status	☐ Active	Review Date: (Calendar)	☐ Completed	Completed Date: (Calendar)	☐ Deferred
Objective#	(text box- in consumer/guardian/family words. Measurable with baseline data and clear indication of progress towards the goal)				
Intervention (Scope)	(text box- service to be provided)				
Amount	(text box- amount of services in a time period i.e. 2x a month)		Duration	(text box- start and end date of service)	
Intensity	(text box- length of service i.e. 20-30 minutes)		Responsible	(text box- primary individual responsible for the service)	
Duration	Start Date		End Date		
Intensity	(text box- length of service i.e. 20-30 minutes)		Responsible	(text box- primary individual responsible for the service)	
Location	(drop down- service locations i.e. home, community, agency)				
Objective#	(text box)				
Intervention (Scope)	(text box)				
Amount	(text box)		Duration	(text box)	
Intensity	(text box)		Responsible	(text box)	
Location	(drop down)				

DISCHARGE/TRANSITION PLAN			
Current Location:		**Discharge Location:**	
Date	Time	Date	Time
Diagnosis appointment:		Date	Time
Supports:			
Community:			

CONSUMER SATISFACTION			
Is consumer/family satisfied with planning process?	☐ Yes	☐ No	(text box- level of satisfaction and opportunity for input)
	☐	☐	

CONSUMER/FAMILY CONFLICT RESOLUTION
(Insert Provider Name) staff have explained to me that if I am not satisfied with my (Insert Service) or any aspect of my services, I may discuss my concerns in-person with my (Insert Staff) or by calling (Insert Staff) at (Insert Phone Number) or by calling (Insert Provider Name) Customer/Member Services at (Insert Phone Number).

TREATMENT PLAN COPIES				
Copy given/sent?	☐ Yes	Date given/sent: (Calendar)	☐ No	Consumer Initials.

SIGNATURES		
CONSUMER		
e-Signature:	Print Name: (text)	
PARENT/GUARDIAN		
e-Signature:	Print Name: (text)	
STAFF **(Program Manager, Doctor, Therapist, Peer, Nurse, etc.)**		
e-Signature:	Print Name: (text)	
Credentials/Job Title: (drop down)	Date: (text)	Time: (text)
INDEPENDENT FACILITATOR		
e-Signature:	Print Name: (text)	
OTHER **(Peer Support Specialist, Youth Advocate, Parent Support Partner, etc.)**		
e-Signature:	Print Name: (text)	