

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

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

INDEPENDENT FACILITATOR		
An independent facilitator has been offered	<input type="checkbox"/> Yes	<input type="checkbox"/> No
An independent facilitator has been requested	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Independent Facilitator brochure provided	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If no, brief explanation provided of Independent facilitation services		
PARTICIPANTS		
(Peer support specialist, youth advocate, parent support partner, independent facilitator, etc.)		
The following individual(s) have been requested at the treatment plan meeting	Name	(text box)
	Relationship	(text box)
	Phone	(text box)
	Who will invite	(text box)
	Name	(text box)
	Relationship	(text box)
	Phone	(text box)
	Who will invite	(text box)
	Name	(text box)
	Relationship	(text box)
	Phone	(text box)
	Who will invite	(text box)
The following person will facilitate the treatment meeting	(Drop Down- the following people will appear in the drop down; primary staff, consumer, parent/guardian, family member, independent facilitator-the field should be expanded to accommodate other designee)	
The following person will record the treatment planning meeting	(Drop Down- the following people will appear in the drop down; primary staff, consumer, parent/guardian, family member, independent facilitator-the field should be expanded to accommodate other designee)	

PRE-PLANNING MEETING			
Consumer/Parent/ Guardian chose to participate in a pre- planning meeting	<input type="checkbox"/> Yes	<input type="checkbox"/> No	(text box, if 'No' is selected please indicate the reason why)
CONSUMER			
e-Signature:		Print Name: (text)	
PARENT/GUARDIAN			
e-Signature:		Print Name: (text)	
STAFF			
e-Signature:		Print Name: (text)	
Credentials/Job Title: (drop down)		Date: (text)	Time: (text)

PLANNING MEETING									
Consumer/Family Choice of Planning Meeting Date	(Calendar)								
Consumer/Family Choice of Planning Meeting Time	(Time)								
Consumer/Family Choice of Planning Meeting Location	(Drop Down- the following locations will appear in the dropdown: office, consumer/family residence, community- the field should be expanded to accommodate other locations)								
<table border="1"> <thead> <tr> <th colspan="4">PRE-PLANNING MEETING</th> </tr> </thead> <tbody> <tr> <td>Consumer/Parent/ Guardian chose to complete my PCP/IPOS today (include date)</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> <td>(text box, if 'No' is selected please indicate the reason why)</td> </tr> </tbody> </table>		PRE-PLANNING MEETING				Consumer/Parent/ Guardian chose to complete my PCP/IPOS today (include date)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	(text box, if 'No' is selected please indicate the reason why)
PRE-PLANNING MEETING									
Consumer/Parent/ Guardian chose to complete my PCP/IPOS today (include date)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	(text box, if 'No' is selected please indicate the reason why)						

ADVANCE DIRECTIVE			
There is an advance directive in place	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
More information about advance directives is requested	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Advance Directive brochure provided	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Advance Directive brief explanation provided	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Opportunity to revisit Advance Directive offered?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A

CRISIS PLAN OFFERED		<input type="checkbox"/> Yes	<input type="checkbox"/> No
If no, brief explanation provided:			
Opportunity to revisit offered?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A

SPECIAL ACCOMODATIONS	
Communication	(text box- identify the specific accommodation to be made)
Environmental	(text box- identify the specific accommodation to be made)
Cultural	(text box- identify the specific accommodation to be made)
Religious	(text box- identify the specific accommodation to be made)
HOPES/DREAMS/DESIRES	
Hopes, Dreams, and Desires are	(text box- identify the specific hopes, dreams, and desires in specific consumer/families words)
Topics to be discussed at the treatment planning meeting	(text box- identify the topics to be discussed in specific consumer/families words)
Topics not to be discussed at the treatment planning meeting	(text box- identify the topics not to be discussed in specific consumer/families words)
SIGNATURES	
CONSUMER	
e-Signature:	Print Name: (text)
PARENT/GUARDIAN	
e-Signature:	Print Name: (text)
STAFF	
e-Signature:	Print Name: (text)
Credentials/Job Title: (drop down)	Date: (text)
	Time: (text)