BAY ARENAC BEHAVIORAL HEALTH AUTHORITY
CRISIS SUPPORT PLAN

I. **Demographic Information** Date:Click or tap here to enter text.

Consumer Name:Click or tap here to enter text.

Address:Click or tap here to enter text.

Phone (Home):Click or tap here to enter text. Phone (Cell):Click or tap here to enter text.

Date of Birth:Click or tap here to enter text. BABHA ID #:Click or tap here to enter text.

Parent/Guardian Name:Click or tap here to enter text.

Emergency Contact (if different):Click or tap here to enter text.

School:Click or tap here to enter text.

Current Mental Health Providers (CSM/OPT/etc.):Click or tap here to enter text.

II. Presenting Concerns

Include onset, duration, intensity, symptoms, and any precipitating event:Click or tap here to enter text.

III. Psychosocial Information

Environmental Concerns & Needs:Click or tap here to enter text.

Support System: Click or tap here to enter text.

School Life:Click or tap here to enter text.

Legal History:Click or tap here to enter text.

Housing Issues:Click or tap here to enter text.

Developmental History: Click or tap here to enter text.

Trauma History: Click or tap here to enter text.

IV. Mental Status Exam (check appropriate items)

Orientation: ☐Person ☐Time ☐Place

Affect: ☐Appropriate ☐Inappropriate ☐Sad ☐Angry ☐Anxious ☐Labile
☐Flat ☐Expansive ☐Other:_____

Mood: ☐Normal ☐Euthymic ☐Depressed ☐Irritable ☐Angry ☐Euphoric

Thought Content:

☐Obsessions (describe):Click or tap here to enter text.

☐Delusions (describe):Click or tap here to enter text.

☐Hallucinations (describe):Click or tap here to enter text.

Thought Processes: ☐Logical ☐Coherent ☐Goal-directed ☐Detailed
☐Tangential ☐Circumstantial ☐Illogical ☐Loose Associations ☐Disorganized
☐Flight of Ideas ☐Perseveration ☐Blocking

Speech: ☐Normal ☐Slurred ☐Slow ☐Rapid ☐Pressured ☐Loud

Motor: ☐Normal ☐Excessive ☐Slow

Intellect: ☐Average ☐Above ☐Below

Insight: ☐Present ☐Partial ☐Impaired
Judgment: ☐Intact ☐Impaired
Impulse Control: ☐Adequate ☐Impaired
Memory: ☐Immediate ☐Recent ☐Remote
Concentration: ☐Intact ☐Impaired
Attention: ☐Intact ☐Impaired
Behavior: ☐Appropriate ☐Inappropriate
Details/additional comments: N/A
Appetite: ☐Normal ☐Increased ☐Decreased
Sleep pattern: ☐Normal ☐Interrupted
Nightmares: ☐Present ☐Absent
Hygiene: ☐Good ☐Fair ☐Poor

V. Risk Assessment

Crisis Triage Rating Scale score:Click or tap here to enter text.
Comments (harm to self/others, plan, intent, etc.):Click or tap here to enter text.

VI. Mental Health/Psychiatric History (include prior tx, previous hospitalizations, etc.)

☐See current assessment in Phoenix
Click or tap here to enter text.

VII. Medical History (include surgeries, etc.)

☐See current assessment in Phoenix
Click or tap here to enter text.

VIII. Medication List:

Click or tap here to enter text.

IX. Substance Use History

☐See current assessment in Phoenix
Click or tap here to enter text.

X. Interim/Short Term Plan Goals/Objectives (check as appropriate)

☐Goal: De-escalate crisis and stabilize individual's condition.
Objective: Utilize therapeutic interventions to improve functioning at school, home, and/or in the community.

☐Goal: Connect individual/family with existing treatment team to re-establish stability.
Objective: Individual/family will attend appointments.

☐Goal: Assist individual/caregiver with scheduling of psychiatric medication evaluation/review.
Objective: Individual will attend psychiatric appointments as scheduled.

☐Goal: Assist individual/family in maintaining present living environment and prevent use of more restrictive level of services.

Objective: Utilize interventions to reduce risk to self or others.

☐Goal: Click or tap here to enter text.

- Objective:

Goals/Objectives Implementation Date:Click or tap here to enter text. Target Date:

XI. DSM V Diagnostic Impression/Clinical Summary

Click or tap here to enter text.

Crisis Plan Reviewed ☐ OR Crisis Plan Completed/Revised ☐

Important: The notice explains your internal appeal rights. Please read this notice carefully. If you need help with this notice or asking for an appeal, you can call one of the numbers listed in the "Get Help & More Information" section of this Notice.

This is to tell you that the following action has been taken: During person centered planning you (may) have requested changes in the amount, scope and duration of the following services: All services. Effective: Date of Plan.

This action is based on the following: Reduction, suspension, or termination of a previously authorized service 42 CFR 438.400(b)(2); and/or 42 CFR 440.230(d), Michigan's Mental Health Code, Public Act 258, and/or applicable policy found in the Medicaid Provider Manual, Mental Health and Substance Abuse Services. These provide the basic legal authority for us to place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures. Section 1557 of the Patient Protection and Affordable Care Act prohibits discrimination based on race, color, national origin, sex, age, or disability. You can share a copy of this decision with your provider so you and your provider can discuss next steps. If your Provider asked for coverage on your behalf, we have sent a copy of this decision to your provider.

IF YOU DON'T AGREE WITH THIS ACTION, YOU HAVE THE RIGHT TO AN INTERNAL APPEAL You have to ask Bay-Arenac Behavioral Health for an internal appeal within 60 calendar days of the date of this notice. You, your representative, or your doctor can send in your request that *must include*: • Your Name • Address • Member Number • Reason for appealing • Whether you want a standard or fast appeal (for an expedited or fast appeal, explain why you need one). • Any evidence you want us to review, such as medical records, doctors' letters, or other information that explains why you need the item or service. If you are asking for a fast appeal, you will need a doctor's supporting statement. Call your doctor if you need this information. Please keep a copy of everything you send us for your records.

There are 2 kinds of internal appeals: Standard Appeal: We'll give you a written decision on a standard appeal within 30 calendar days after we get your appeal. Our decision might take longer if you ask for an extension, or if we need more information about your case. We'll tell you if we're taking extra time and will explain why more time is needed. If your appeal is for payment of a service you've already received, we'll give you a written decision within 60 calendar days. If you want to ask for an Internal Appeal either call or send in a written request to: Bay-Arenac Behavioral Health 909 Washington Ave, Suite 3, Bay City, MI 48708 Phone Number: Toll-free 1-888-482-8269 or 989-497-1302 Fax Number: 989-895-2715 For hearing or speech assistance, please call Michigan Relay at 7-1-1. **Expedited or "Fast" Appeal: Expedited or Fast Appeal** - We'll give you a decision on a fast appeal within 72 hours after we get your appeal. You can ask for a fast appeal if you or your doctor believe your health could be seriously harmed by waiting up to 30 calendar days for a decision. We'll automatically give you a fast appeal if a doctor asks for one for you or if your doctor supports your request. If you ask for a fast appeal without support from a doctor, we'll decide if your request requires a fast appeal. If we don't give you a fast appeal, we'll give you a

decision within 30 calendar days. To ask for a Fast Appeal, you must call: Toll-free 1-888-482-8269 or 989-497-1302 For hearing or speech assistance, please call Michigan Relay at 7-1-1.

CONTINUATION OF SERVICE DURING AN INTERNAL APPEAL If you are receiving a Michigan Medicaid service and you file your appeal within 10 calendar days of this Notice of Benefit Determination, you may continue to receive your same level of services while your internal appeal is pending. You have the right to request and receive benefits while the internal appeal is pending, and should submit your request to Bay-Arenac Behavioral Health. Your benefits for that service will continue if you request an internal appeal within 10 calendar days from the date of this notice or from the beginning of the intended effective date of the proposed adverse action whichever is later.

IF YOU WANT SOMEONE ELSE TO ACT FOR YOU You can name a relative, friend, attorney, doctor, or someone else to act as your representative. If you want someone else to act for you, call us at Toll-free 1-888-482-8269 or 989-497-1302 to learn how to name your representative. For hearing or speech assistance, call Michigan Relay at 7-1-1. Both you and the person you want to act for you must sign and date a statement confirming this is what you want. You'll need to mail or fax this statement to us. Keep a copy for your records.

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

WHAT HAPPENS NEXT? • If you ask for an internal appeal and we continue to deny your request for coverage or payment of a service, we will send you a written Notice of Appeal Denial. If the service is covered by Michigan Medicaid, you can ask for a Medicaid State Fair Hearing. • The Notice of Appeal Denial will give you additional information about the State Fair Hearings process and how to file the request. • If you do not receive a notice or decision about your internal appeal within the timeframes listed above, you may also seek a State Fair Hearing with the Michigan Office of Administrative Hearings and Rules. Get Help & More Information If you need additional help or additional information about our decision and the internal appeal process, please call Bay-Arenac Behavioral Health Customer Service Department Toll-free 1-888-482-8269 or 989-497-1302 For hearing or speech assistance, please call Michigan Relay at 7-1-1 for assistance. Our hours of operation are Monday through Friday, 8:00 AM to 5:00 PM You can also visit our website at www.babha.org Michigan Department of Health and Human Services (MDHHS) Beneficiary Help Line: 1-800-642-3195. TTY users call 1-866-501-5656 or 1-800-975-7630 (if calling from an internet-based phone service).

The legal basis for this decision is 42 CFR 440.230(d), Michigan's Mental Health Code, Public Act 258, and/or applicable policy found in the Medicaid Provider Manual, Mental Health and Substance Abuse Services. These provide the basic legal authority for us to place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures. Section 1557 of the Patient Protection and Affordable Care Act prohibits discrimination based on race, color, national origin, sex, age, or disability.

Screener Name: Click or tap here to enter text.

Screener Signature and Credentials / Date:

_____

_____ Click or tap here to enter text._____

Consumer/Guardian/Parent Signature **Printed Name** **Date**