MSHN
Mid-State Health Network

CMHSP CLINICAL RECORD REVIEW

	Standard/Requirement	Source(s) Evidence of Compliance May Include:	Review Guidelines for Review Team	Provider to Complete: list evidence provided and location
1	**Intake/Assessment**			
1.1	Is there a copy of the Initial Assessment (if open for less than one year) or timely Re-Assessment (if open for more than one year) in the file?	Medicaid Provider Manual: Mental Health/Substance Abuse Chapter; Section 3.3 Code of Federal Regulations: 438.208(c)(2) & 438.208(c)(3)(v)	LOC evaluations are completed accurately If this is an updated assessment, was information updated? Annual LOCUS, Nursing, Assessment/Medical Information, Improvement/ Decompensation Reflected?	
1.2	Are consumer's needs & wants documented?	MDHHS Person-Centered Planning Policy		
1.3	Consumer chart reflects input and coordination with others involved in treatment.	Code of Federal Regulations: 438.208(b)(1); 438.208(b)(2); 438.208(b)(3) Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program Person Centered Planning Policy	Please note potential health & safety issues for non-coordination of care. Information from other treatment providers is not always known at time of assessment (particularly initial assessment); however, the consumer chart contains evidence of CMHSP efforts to coordinate care and obtain input. Evidence may include progress notes, non-billable contact notes, coordination letters, records requests to other providers, etc.	

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1.4	Present and history of behavioral and/or symptoms are documented based on information provided by the beneficiary, beneficiary's family, and/or other individuals who know the beneficiary and health care professionals who have evaluated the beneficiary.	Medicaid Manual, 2.5 B Determination Criteria		
1.5	Substance use (current and history) included in assessment.	MDHHS/PIHP Medicaid Managed Specialty Supports and Services contract, Access System Standard Guidelines	Assessment includes evidence that substance use was addressed accurately.	
1.6	Current physical health conditions are identified.	MDHHS/PIHP Medicaid Managed Specialty Supports and Services contract	Please note potential health & safety issues for non-coordination of care.	
1.7	Current health care providers are identified by name and contact information, including primary care physician.	MDHHS Access System Standards		
1.8	Previous behavioral health treatment and response to treatment identified.	MDHHS Person-Centered Planning Policy MDHHS Inclusion Practice Guideline Medicaid Manual (Psychiatric Evaluation/Assessment Section)		
1.9	Present and history of trauma is screened for and identified (abuse, neglect, violence, or other sources of trauma) using a validated, population-appropriate screening tool.	BHDDA Trauma Policy	Reviewer to ensure valid screening tool used at intake/assessment as clinically appropriate	

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1.10	Did crisis screening and other life domains that need screening occur?	MDHHS Access System Standards R 330.7199, MDHHS Person Centered Planning Policy		
1.11	Was consumer offered the opportunity to develop a Crisis Plan? .	MDHHS Customer Service Standards	Please note potential health & safety issues for non-coordination of care. If risk of harm to self or others has been identified a crisis plan must be completed and present in record. For recipients of home-based services, a crisis plan must be completed.	
2	**Pre- Planning**			
2.1	Did pre-planning occur prior to Person-Centered Planning meeting or the development of a plan?	MDHHS Person-Centered Planning Policy	Was sufficient time given to take all needed actions (e.g., invite desired participants)? If the pre-plan occurred same day as planning meeting, is there documentation as to why?	
2.2	Pre-planning addressed when and where the meeting will be held.	MDHHS Person-Centered Planning Policy	Preplan documentation includes decision for when & where meeting is held. If preplan occurs same day as planning meeting, is there justification for why, i.e., consumer requested the preplan occur same day as meeting.	
2.3	Pre-planning addressed who will be invited (including whether the person has allies who can provide desired meaningful support or if actions need to be taken to cultivate such support).	MDHHS Person-Centered Planning Policy	were all relevant parties invited and/or considered for the meeting, i.e., doctor/nurse/psychiatrist/etc. If any party was not included/invited, is there documentation to justify reasoning, i.e., CM collected information on	

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			behalf of psychiatrist & will include psychiatric feedback in planning.	
2.4	Individual chose topics they would like to talk about in the meeting(s) and topics they do not want discussed at the meeting(s).	MDHHS Person-Centered Planning Policy	Preplan includes documentation of what will and/or will not be discussed.	
2.5	Pre-planning addressed who will facilitate the meeting.	MDHHS Person-Centered Planning Policy		
2.6	Evidence enrollee had an ability to choose among various services.	Medicaid Manual, MDHHS Person-Centered Planning Policy	Evidence may include: Administrative records policies and procedures, Individual records, Consumer/Family interviews (PM-D-9)	
2.7	Evidence enrollee had an opportunity to choose their providers.	MDHHS Person-Centered Planning Policy, MDHHS/PIHP Medicaid Managed Specialty Supports and Services contract, Medicaid Manual, Medicaid Subcontract	Administrative records policies and procedures, Individual records, Consumer/Family interviews CWP- Parent/guardian signature on the certification form	
2.8	Individual received complete and unbiased information on services and supports available, community resources, and options for providers which are documented in the IPOS.	MDHHS Person-Centered Planning Policy		
3	**Person Centered Planning /Individual Plan of Service**			
3.1	The IPOS must be prepared in person-first singular language and can be understandable by the person with a minimum of clinical jargon or language.	MDHHS Person-Centered Planning Policy		

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3.2	The IPOS includes the following components described below: A description of the individual's strengths, abilities, plans, hopes, interests, preferences, and natural supports.	MDHHS Person-Centered Planning Policy		
3.3	The individual's cultural preferences are recognized, respected, and incorporated in the planning process and documented in the IPOS, including but not limited to language access, race, gender identify, sexual orientation, religion, dietary preferences, etc.	MDHHS Person-Centered Planning Policy	Evidence in the preplan or IPOS that cultural preferences are being incorporated.	
3.4	The goals and outcomes identified by the person and how progress toward achieving those outcomes will be measured.	MDHHS Person-Centered Planning Policy		
3.5	The services and supports needed by the person to work toward or achieve his or her outcomes including those available through the CMHSP, other publicly funded programs, community resources, and natural supports.	MDHHS Person-Centered Planning Policy Consumerism Practice Guideline	The PCP Policy and Practice Guidelines no longer identifies "ongoing" as part of this. It may be helpful for MSHN to define "ongoing."	
3.6	The setting in which the person lives was chosen by the person and what alternative living settings were considered by the person. The chosen setting must be integrated in and support full access to the greater community, including	MDHHS Person-Centered Planning Policy	Was the consumer able to choose the setting? If not, is there justification as to why, e.g., no available homes that can accommodate individual's needs, etc. Reviewer would know what to look for via assessment	

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	opportunities to seek employment & work in competitive integrated settings, engage in community life, control person resources, and receive services in the community to the same degree of access as individuals not receiving services and supports from the mental health system.		documentation. Assessment should include current residence, any changes to residence, reason for change(s), etc. Setting should meet consumer's wants/needs and/or CMHSP should work with consumer on alternative options. Scoring NA is acceptable Discuss with provider if there is any question.	
3.7	The amount, scope, and duration of medically necessary services and supports authorized by and obtained through the community mental health system.	MDHHS Person-Centered Planning Policy	Ensure amount, scope, and duration are included in PCP. Ensuring that amount, scope, and duration are met is completed in Section 6. Autism- verify 10% requirements for observation and direction is met	
3.8	Documentation that the IPOS prevents the provision of unnecessary supports or inappropriate services and supports.	MDHHS Person-Centered Planning Policy	If there is a question/concern about supports and services, work with provider. Did the provider document discussion(s) about the appropriateness of services & supports? Was an alternative plan discussed?	
3.9	There is documentation of any restriction or modification of additional conditions & documentation includes:	MDHHS Person-Centered Planning HCBS Final Rule, Medicaid Provider Manual		

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	1. The specific & individualized assessed health or safety need. 2. The positive interventions and supports used prior to any modifications or additions to the PCP regarding health or safety needs. 3. Documentation of less intrusive methods of meeting the needs, that have been tried but were not successful. 4. A clear description of the condition that is directly proportionate to the specific assessed health or safety need. 5. A regular collection and review of data to measure the ongoing effectiveness of the modification. 6. Established time limits for periodic reviews to determine if the modification is still necessary or can be terminated. 7. Informed consent of the person to the proposed modification. 8. An assurance that the modification itself will not cause harm to the person.			

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3.10	If applicable, behavior treatment plans are developed in accordance with the Technical Requirement for Behavior Treatment Plan Review Committees.	MDHHS Technical Requirement for Behavior Treatment Plan Review Committees	1. Documentation that plans that proposed to use restrictive or intrusive techniques are approved (or disapproved) by the committee 2. Documentation that plans which include restrictive/intrusive interventions include a functional behavior assessment and evidence that relevant physical, medical and environmental causes of challenging behavior have been ruled out. 3. Are developed using the PCP process and reviewed quarterly 4. Are disapproved if there is a recommendation for the use of aversive techniques, physical management, or seclusion or restraint in the plan 5. Written special consent is obtained before the behavior treatment plan is implemented; positive behavioral supports and interventions have been adequately pursued (i.e. at least 6 months within the past year) 6. The committee reviews the continuing need for any approved procedures involving intrusive or	

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			restrictive techniques at least quarterly.	
3.11	The services which the person chooses to obtain through arrangements that support self-determination.	MDHHS Person-Centered Planning Policy, Medicaid Provider Manual: Mental Health/Substance Abuse Chapter; Section 2: Program Requirements		
3.12	The beneficiary was an active participant in the decision for telemedicine as a means of service delivery as appropriate.	MI Medicaid Provider Manual; Telemedicine, Section 1	Does the beneficiary prefer telemedicine to an in-person visit? What is the optimal combination of ongoing service delivery for the individual?	
3.13	The estimated/prospective cost of services and supports authorized by the CMHSP	MDHHS Person-Centered Planning Policy, MDHHS Technical Advisory for Estimated Cost of Services		
3.14	Signature of the person and/or representative, his or her case manager or support coordinator, and the support broker/agent (if one is involved).	R330.7199 (Written Plan of Service) Medicaid Provider Manual: Mental Health/Substance Abuse Chapter; Section 2: Program Requirements		
3.15	The plan for sharing the IPOS with family/friends/caregivers with the permission of the person.	MDHHS Person-Centered Planning Policy	Did the CMHSP document who/how/when the plan will be shared? Was consent obtained?	
3.16	A timeline for review.	Michigan Administrative Code: R330.7199 (Written Plan of Service)		
3.17	Accommodations available for individuals accessing services who experience			

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	hearing or vision impairments, including that such disabilities are addressed in clinical assessments and service plans as requested by the person receiving services			
3.18	If applicable, the IPOS addresses health and safety issues.	MDHHS Person-Centered Planning Policy	*Please note potential health & safety issues for non-coordination of care.	
3.19	If applicable, trauma is addressed as part of PCP.	BDHHA Trauma Policy		
3.20	The consumer/guardian was given a copy of the Individual Plan of Service within 15 business days?	MDHHS Person-Centered Planning Policy		
3.21	Consumer has ongoing opportunities to provide feedback on satisfaction with treatment, services, and progress towards valued outcomes.	MDHHS Person-Centered Planning Policy		
3.22	For children's services: The plan is family-driven, and youth guided.	Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver , MDHHS Person-Centered Planning Policy, Family Driven and youth Guided Policy and Practice Guideline, Michigan Administrative Code: R330.7199 (Written Plan of Service), Medicaid Provider Manual: Mental Health/Substance Abuse Chapter; Section 7.1		
3.23	**AUTISM**	MDHHS Medicaid Provider Manual		

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	As part of the IPOS, there is a comprehensive, individualized behavioral plan of care that includes specific targeted behaviors, along with measurable, achievable, and realistic goals for improvement. BCBAs/LBAs and other qualified providers develop, monitor, and implement the behavioral plan of care. These providers are responsible for effectively evaluating the child's response to treatment and skill acquisition.			
3.24	**CRISIS RESIDENTIAL** • IPOS is developed within 48-hours of admission. • Includes discharge planning information & need for aftercare/follow-up services • Includes case manager • If stay exceeds 14-days, interdisciplinary team develops a subsequent plan based on comprehensive assessments	Medicaid Provider Manual, Mental Health/Substance Abuse, Section 6		
4	**Documentation**			
4.1	Consumer was provided written information related to Recipient Rights?	Code of Federal Regulations 438.10 (Information Requirements) and 438.100 (Enrollee Rights), PIHP Customer Services Standards		

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		Grievance and Appeal Technical Requirement		
4.2	Consumer was given accurate and timely information about the Grievance and Appeal Process?	Code of Federal Regulations 438.10 (Information Requirements) and 438.100 (Enrollee Rights), PIHP Customer Services Standards	At intake and annually there after	
4.3	All forms/documents placed in consumer records identify the consumer with name and medical record number	Medicaid Provider Manual Section 14 Record Keeping		
4.4	There is documentation in a prominent part of the beneficiary's current medical record as to whether or not the beneficiary has executed an advance directive.	42 CFR 422.128 (b)(1)(ii)(E)		
5	**Customer Service**			
5.1	Decisions to deny or authorize service in an amount, duration or scope that is less than requested are made by a health care professional who has the appropriate clinical expertise in treating the consumer's condition or disease.	Appeal and Grievance Resolution Processes Technical Requirement		
5.2	The CMHSP provides Medicaid consumers with written service authorization decisions no later than 14 calendar days following receipt of a request for service authorization, unless the PIHP has authorized an extension; or	Appeal and Grievance Resolution Processes Technical Requirement		

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	the CMHSP provides Medicaid consumers with written service authorization decisions no later than 72 hours following receipt of a request for expedited service authorization, if warranted by the consumer's health or functioning, unless the PIHP has authorized an extension.			
5.3	The reasons for the service denial decision(s) is/are clearly documented and provided to the recipient.	Appeal and Grievance Resolution Processes Technical Requirement		
5.4	When denied or when services were authorized in an amount, duration or scope that was less than requested was the involved provider, if applicable, informed verbally or in writing of the action?	Appeal and Grievance Resolution Processes Technical Requirement		
5.5	A second opinion from a qualified health care professional within or outside the network is available to consumers upon request, at no cost to the consumer.	42 CFR 438.206(b)(3), R 330.7005		
6	**DELIVERY AND EVALUATION**			
6.1	Are services being delivered consistent with plan in terms of scope, amount, and duration?	Medicaid Provider Manual		

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6.2	Monitoring and data collection on goals is occurring according to time frames established in plan?	Medicaid Provider Manual		
6.3	Are periodic reviews occurring according to time frames established in plan and as warranted by clinical changes and needs.	Medicaid Provider Manual		
7	**PROGRAM SERVICE DELIVERY**			
7.1	For medication services: • informed consent was obtained for all psychotropic medication • evidence consumer informed of their right to withdraw consent at any time	Medicaid Provider Manual		
7.2	Is there a physician prescription or referral for each specialized service (Physical Therapy, Occupational Therapy, Speech Therapy, durable medical equipment etc.)?	Medicaid Provider Manual	Evidence: Physician-signed prescriptions for OT and PDN services are in the file and include a date, diagnosis, specific service, or item description, start date and the amount or length of time the service is needed.)	
7.3	Is there direct access to a specialist, as appropriate for the individual's health care condition?	Code of Federal Regulations: 438.208 (4)		
7.4	Is there evidence of coordination with Primary Care Physician in the record? If not, is there evidence of referral to a PCP? If client declined referral, is there documentation of client decline?	Code of Federal Regulations: 438.208(b) PIHP Customer Services Standards		

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7.5	**ACT SERVICES** a. all members of the team routinely have contact with the individual b. right to withdraw consent c. majority of services occur in consumer home or community	Michigan Medicaid Manual Section 4		
7.6	**ACT Services** The total number of contacts averages 120 minutes of face to face time each week for each beneficiary; clearly documented clinical rationale is provided in exception cases where an average of 120 minutes is not clinically appropriate.	Medicaid Provider Manual 4.4		
7.7	**INTENSIVE CRISIS STABILIZATION SERVICES** Face to face contacts are occurring within one hour or less in urban counties and in two hours in rural counties from the time of the request for ICSS	Medicaid Provider Manual, Section 9; 9.2.B Population– Intensive Crisis Stabilization Services		
7.8	**INTENSIVE CRISIS STABILIZATION SERVICES** Services include: • Assessment • Intensive individual counseling/psychotherapy • Family therapy • Skill building • Psychoeducation	Medicaid Provider Manual, Section 9; 9.2.C Population– Intensive Crisis Stabilization Services 9.2.D Qualified Staff- Intensive Crisis Stabilization Services		

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	There is evidence of access to an on-call psychiatrist for team members (must always be available by telephone).			
7.9	**INTENSIVE CRISIS STABILIZATION SERVICES** For children: ICSS staff consists of at least two who travel to the child or youth in crisis. One team member must be a Master's prepared Child Mental Health Professional (or master's prepared QIDP, if applicable) and the second team member may be another professional or para-pro under appropriate supervision.	Medicaid Provider Manual, Section 9; 9.2.D. Qualified Staff- Intensive Crisis Stabilization Services		
7.10	**INTENSIVE CRISIS STABILIZATION SERVICES** For adult recipients: An ICSS treatment plan is developed within 48 hours. If the beneficiary receives case management services, the case manager must be involved in the treatment and follow-up services For children/youth: If the child or youth is a current recipient of CMHSP services, the existing IPOS and crisis/safety plan must be updated For children or youth who are not yet recipients of CMHSP services but are	Medicaid Provider Manual, Section 9; 9.2.C Population– Intensive Crisis Stabilization Services		

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	eligible for such services, a family-driven and youth-guided follow-up plan must be developed.			
7.11	**INTENSIVE CRISIS STABILIZATION SERVICES** If the child or youth is a current recipient of CMHSP services, there is evidence of the mobile intensive crisis stabilization team members notifying the primary therapist, case manager, or Wraparound facilitator, as applicable, of the contact with the mobile intensive crisis stabilization team the next business day. Evidence that a follow-up contact has been made with the child or youth and parent/caregiver by the primary therapist, case manager, or wraparound facilitator once the primary case holder was informed of the child or youth's contact with the ICSS team.	Medicaid Provider Manual, Section 9; 9.2.C Population– Intensive Crisis Stabilization Services		
7.12	**INTENSIVE CRISIS STABILIZATION SERVICES** If the child or youth is not yet a recipient of CMHSP services but is eligible for such services, the follow-up plan must include: -Appropriate referrals to mental health assessment and treatment resources and	Medicaid Provider Manual, SECTION 9; 9.2.F. Individual Plan of Service – Intensive Crisis Stabilization Services		

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	any other resources the child or youth and parent/caregiver may require - Next steps for obtaining needed services, timelines for those activities, and identifies the responsible parties. - The mobile intensive crisis stabilization team members have contacted the parent/caregiver by phone or face-to-face within seven business days to determine the status of the stated goals in the follow-up plan			
7.13	**HOME BASED SERVICES** Services are provided in the family home or community to an expected/acceptable frequency.	Medicaid Provider Manual, Mental Health and Substance Abuse Services Chapter, Section 7.1	Guidance: Chart verification via progress notes that indicate services are being offered both within the home and within the community.	
7.14	**HOME BASED SERVICES** A minimum of 4-hours of individual and/or family face-to-face home-based services per month are provided by the primary home-based services worker (or, if appropriate, the evidence-based practice therapist).	Medicaid Provider Manual, Mental Health and Substance Abuse Services Chapter, Section 7.1	Guidance: Chart verification via progress notes.	
7.15	**WRAPAROUND** Record indicates adherence to Wraparound model fidelity via: • Team Membership Form completed quarterly & upon changes	MDHHS Letter: L22-26, Medicaid Provider Manual 3.29.E		

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	• Supervisor participates on community team Fidelity Form completed at 6 & 12 months.			
7.16	**SELF DIRECTED SERVICES** There is a copy of the SD Budget	SD P&PG, Policy § II. A	Guidance: Copy of Budget is considered evidence of compliance.	
7.17	**SELF DIRECTED SERVICES** There is a copy of the SD Agreement	SD P&PG, Policy § II. E	Guidance: Copy of Self Determination Agreement	
7.18	**SELF DIRECTED SERVICES** There is evidence that individual has assistance in selecting, employing, and directing & retaining qualified providers.	SD P&PG, Policy § IV.m	Review file for evidence of hiring own staff for providers or agency with choice model; education materials/training materials provided; etc.	
7.19	**CRISIS RESIDENTIAL** If stay exceeds 14 days, the interdisciplinary team developed a subsequent plan based on comprehensive assessments.	Medicaid Provider Manual		
7.20	**CRISIS RESIDENTIAL** If the individual has an assigned case manager, the case manager must be involved in treatment, as soon as possible, including follow-up services.	Medicaid Provider Manual, Mental Health/Substance Abuse, Section 6 (6.8)		
7.21	**AUTISM BENEFIT/APPLIED BEHAVIORAL ANALYSIS** Evidence of measurable and ongoing improvement in targeted behaviors that are demonstrated with the use of reliable	Medicaid Provider Manual MHSA Section 18		

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	and valid assessment instruments and other appropriate documentation of analysis (i.e., graphs, assessment reports, records of service, progress reports, etc.).			
7.22	**AUTISM BENEFIT/APPLIED BEHAVIORAL ANALYSIS** Services provided to individual were provided by staff meeting all qualifications for ABA service delivery.	Medicaid Provider Manual	Use supplemental Autism qualification review tools	
7.23	**BEHAVIORAL HEALTH HOMES** At a minimum, the care plan should include the following: • tasks to be completed by each HH team member. • The tasks to be completed by the beneficiary. • SMART goals and objectives developed by and agreed upon by the beneficiary, and HH care team to achieve improved health outcomes. • Align with the six required health home services. • Integrate the beneficiary's physical health, behavioral health, and social support needs. • A plan to monitor the health home care plan progress and update goals.	BHH Handbook	Chart review; care plan	

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7.24	**BEHAVIORAL HEALTH HOMES** Service provided met criteria for a Health Home service.	BHH Handbook	Chart review; Health Home Needs Assessment	
7.25	**BEHAVIORAL HEALTH HOMES** If needs are identified on the care plan, a referral or services provided, meeting the need identified.	BHH Handbook	Chart review; care plan, progress notes, coordination of care letter, etc.	
7.26	**BEHAVIORAL HEALTH HOMES** Each beneficiary has been designated a care coordinator	BHH Handbook	Chart review, Health Home Needs Assessment, care plan, etc.	
7.27	**BEHAVIORAL HEALTH HOMES** An assessment, screening, etc. to identify needs has been completed.	BHH Handbook	Social determinants of health screen; Biopsychosocial assessment; Health Home Needs Assessment	
8	**Discharge /Transfers**			
8.1	For closed cases, was the discharge summary/transfer completed in a timely manner? (Consistent with CMSHP policy)	PIHP / MDHHS Contract Medicaid Provider Manual		
8.2	Does the discharge/transfer documentation include: a. Statement of the reason for discharge; and Individual's status /condition at discharge	Medicaid Provider Manual 42 CFR 438.208(b)(2)(i) MCL 330.1712 Reporting Requirements for BH-TEDS		
8.3	b. Does the discharge record include a plan for re-admission to services if necessary?	Medicaid Provider Manual		
8.4	Does the documentation include: a. Recommendations. b. Referrals; and	Medicaid Provider Manual	*Please note potential health & safety issues for non-coordination of care.	

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	c. Follow up contacts			
9	**Integrated Physical and Mental Health Care**			
9.1	The CMHSP encourages all consumers eligible for specialty mental health services to receive a physical health assessment including identification of the primary health care home/provider, medication history, identification of current and past physical health care and referrals for appropriate services.	MDHHS/PIHP Medicaid Managed Specialty Supports and Services contract		
9.2	CMHSP staff pro-actively assume responsibility for engaging the inpatient team during consumer's hospital stay. This includes participating in team meetings and initiating discharge planning with staff, consumer, family/guardian, and community resources.	MSHN Inpatient Psychiatric Hospitalization Standards Policy		
9.3	As authorized by the consumer, the CMHSP includes the results of any physical health care findings that relate to the delivery of specialty mental health services and supports in the person-centered plan.	MDHHS/PIHP Medicaid Managed Specialty Supports and Services contract	Progress notes, continuing stay reviews or hospital discharge plans showing evidence of CMHSP participation	
9.4	The CMHSP will ensure that a basic health care screening/health appraisal, including height, weight, blood pressure,	MDHHS/PIHP Medicaid Managed Specialty Supports and Services contract	copies of annual physical exams by a primary care physician/physician assistant, a nursing heath	

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	and blood glucose levels is performed on individuals who have not visited a primary care physician, even after encouragement, for more than 12 months. Health conditions identified through screening should be brought to the attention of the individual along with information about the need for intervention and how to obtain it.		assessments, a psychiatric evaluation or an annual self-assessment by the individual, with the primary case holder, if based on a range of health care categories/need (i.e., current medications, vision, hearing, date of last primary care physician visit, health conditions, BMI, nutritional needs, etc.), along with planned coordination to occur (based on those needs) with the primary care physician (or other health care providers, as appropriate). An annual self-assessment document would need to be signed/dated by the primary case holder (SC, CM, Wraparound Facilitator, etc.) to meet this standard."	