N J Department of Human Services

Community Support Services – Individualized Rehabilitation Plan Modification

IRP Modification Form #1 – For more Units &/or New Goal

Submit to IME with page 3 and page 4, signatures completed

Please check the one that apply: ☐ Adding a New Goal for the current IRP (Page 1) ☐ Modifying an Existing Goal from the current IRP(Page 2)

☐ **Adding a New Goal**	
Consumer Name: *	Consumer Medicaid ID: *
Agency Name: *	Agency CSS Medicaid ID: *

Goal from CRNA:						
Valued Life Role:	Wellness Dimension:					
Strengths Related to Goal:						
CSS Intervention(s)	**Responsible Credential**	**Location of Service**	**Frequency**	**Duration**	**Band # / HCPCS Code**	**# of Units**
KSR Development/Measurable Objective Select One :						
KSR Development/Measurable Objective Select One :						
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☐ **Modifying an existing goal from the current IRP**	
Consumer Name: *	Consumer Medicaid ID: *
Agency Name: *	Agency CSS Medicaid ID: *

If this is a modification of an existing goal, please identify the Rehabilitation Goal and Objective being modified from the current IRP:

Goal Select a no. | **Goal from CRNA:**

KSR Development/Measurable Objective Select One :

CSS Intervention(s)	Responsible Credential	Location of Service	Frequency	Duration	Band # / HCPCS Code	# of Modified Units

Justification for Modification:

If this is a modification of an existing goal, please identify the Rehabilitation Goal and Objective being modified from the current IRP:

Goal Select a no. | **Goal from CRNA:**

KSR Development/Measurable Objective Select One :

CSS Intervention(s)	Responsible Credential	Location of Service	Frequency	Duration	Band # / HCPCS Code	# of Modified Units

Justification for Modification:

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Consumer Name: *	Consumer Medicaid ID: *
Agency Name: *	Agency CSS Medicaid ID: *

	BAND # + HCPC Code	**MEDICAID**		**STATE**		
Responsible Credentials In each Band	**#1 = H2000 HE #2 = H2000 HE SA #3 = H2015 #4 = H0039 #5 = H0036**	**Request for Prior Authorization (PA) Medicaid # of units per band**	**# of units approved *(28 units daily max except Band 1 & 2)***	**Request for Prior Authorization (PA) State Funded # of units per band**	**# of units approved *(28 units daily max except Band 1 & 2)***	**IRP Start Date**
1. Physician, Psychiatrist ***(max 8 units daily)***						Pick a date.
2. Advanced Practice Nurse ***(max 12 units daily)***						Pick a date.
3. RN, Psychologist, Licensed Practitioner of the Health Arts, including: Clinical Social Worker, Licensed Rehabilitation Counselor, Licensed Professional Counselor, Licensed Marriage and Family Therapist, Master's Level Community Support Staff						Pick a date.
4. Bachelor's Level Community Support Staff, LPN ***(Individual)***						Pick a date.
4. Bachelor's Level Community Support Staff, LPN ***(Group)***						Pick a date.
5. Associate's Level Community Support Staff, High School Level Community Support Staff, Peer Level Community Support Staff ***(Individual)***						Pick a date.
5. Associate's Level Community Support Staff, High School Level Community Support Staff, Peer Level Community Support Staff ***(Group)***						Pick a date.
Total # of Units ☐ Preliminary **(60 days**) For Provider file ☐ Completed (**180 days)** Send to IME						

SIGNATURES AND CREDENTIALS

The development of this Individualized Rehabilitation Plan was a consumer driven process that identifies consumer driven goals.

Was the consumer educated and asked to complete a psychiatric advance directive during the development of this plan?			
☐ Yes. But consumer did not wish to complete a psychiatric directive at this time. Staff will follow up during the next IRP.	☐ Yes. But consumer already has a completed psychiatric advance directive.	☐ Yes. Staff will work with consumer to develop a psychiatric advance directive.	☐ No. Consumer was not educated and asked about a psychiatric advance directive.

Consumer Name	Signature	Date
Licensed Clinical Staff Team Member Name/Credentials	Signature	Date
Contributing Team Member Name/Credentials	Signature	Date
Contributing Team Member Name/Credentials	Signature	Date
Optional Signatures: (family members, team member, etc.)	Signature	Date
Optional Signatures: (family members, team member, etc.)	Signature	Date

Please send this form to UBHC IME UM via email at imecss@ubhc.rutgers.edu or fax (732) 235-5569;
Call us at (844) 463-2771

N J Department of Human Services

Community Support Services – Individualized Rehabilitation Plan Modification

IRP Modification Form #2 – For New Band

Submit to IME with page 6 and page 7, signatures completed

Consumer Name: *	Consumer Medicaid ID: *
Agency Name: *	Agency CSS Medicaid ID: *

Rehabilitation Goal from CRNA:						
Valued Life Role:	Wellness Dimension:					
Strengths Related to Goal:						
KSR Development/Measurable Objective #1:						
CSS Intervention(s)	Responsible Credential	Location of Service	Frequency	Duration	Band # / HCPCS Code	# of Units
KSR Development/Measurable Objective #2:						
CSS Intervention(s)	Responsible Credential	Location of Service	Frequency	Duration	Band # / HCPCS Code	# of Units
KSR Development/Measurable Objective #3:						
CSS Intervention(s)	Responsible Credential	Location of Service	Frequency	Duration	Band # / HCPCS Code	# of Units

IRP Modification Form #2 – For New Band

Submit to IME with page 6 and page 7, signatures completed

Consumer Name: *	Consumer Medicaid ID: *
Agency Name: *	Agency CSS Medicaid ID: *

	BAND # + HCPC Code	MEDICAID		STATE		
Responsible Credentials In each Band	**#1 = H2000 HE #2 = H2000 HE SA #3 = H2015 #4 = H0039 #5 = H0036**	**Request for Prior Authorization (PA) Medicaid # of units per band**	**# of units approved *(28 units daily max except Band 1 & 2)***	**Request for Prior Authorization (PA) State Funded # of units per band**	**# of units approved *(28 units daily max except Band 1 & 2)***	**IRP Start Date**
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Total # of Units ☐ Preliminary **(60 days**) For Provider file ☐ Completed (**180 days)** Send to IME						

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