

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 curren	t IRP (Page 1)] Modifying an	Existing Goal	from the c	urrent IRP(Pa	ige 2)	
Adding a New Goal							
Consumer Name: *	Consumer M	ledicaid ID: *					
gency Name: * Agency CSS Medicaid ID: *							
Goal from CRNA:							
Valued Life Role:							
Strengths Related to Goal:	.						
CSS Intervention(s)	Responsible	Location of	Frequency	Duration	Band #	# of	
	Credential	Service	riequency	Duration	HCPCS Code	Units	
KSR Development/Measurable Objective Select One:		1	T	1	1	1	
						-	
						-	
KSR Development/Measurable Objective Select One :			1				
						_	
KSR Development/Measurable Objective Select One :		1	1			l.	
						1	
						-	

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Modifying an existing goal from the current IRP							
Consumer Medicaid ID: *							
Agency CSS 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 :							
Responsible	Location of	F	Duration	Band #	# of Modified		
Credential	Service	Frequency		HCPCS Code	Units		
-		•	u.	1	ľ		
tion Goal and	Obiective bein	g modified fr	om the cui	rent IRP:			
tion Goal and	Objective beir	g modified fr	om the cui	rrent IRP:			
tion Goal and	Objective beir	g modified fr	om the cui	rrent IRP:			
I		g modified fr	om the cui	rent IRP: Band #	# of		
Responsible Credential	Objective beir Location of Service	g modified fr	om the cui		Modified		
Responsible	Location of			Band #	1		
Responsible	Location of			Band #	Modified		
Responsible	Location of			Band #	Modified		
Responsible	Location of			Band #	Modified		
Responsible	Location of			Band #	Modified		
Responsible	Location of			Band #	Modified		
Responsible	Location of			Band #	Modified		
Responsible	Location of			Band #	Modified		
Responsible	Location of			Band #	Modified		
	Agency CSS Nation Goal and	Agency CSS Medicaid ID: * Ition Goal and Objective being Responsible Location of	Agency CSS Medicaid ID: * Ition Goal and Objective being modified fr Responsible Location of Frequency	Agency CSS Medicaid ID: * Ition Goal and Objective being modified from the cur Responsible Location of Frequency Duration	Agency CSS Medicaid ID: * Ition Goal and Objective being modified from the current IRP: Responsible Location of Frequency Duration		

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

onsumer Name: * Consumer Medicaid ID: *									
Agency Name: *				Agency CSS Medicaid ID: *					
	BAND # + HCPC Code	MEDICA		MEDICAID STATE		ATE			
Responsible Credentials In each Band	#1 = H2000 HE #2 = H2000 HE SA #3 = H2015 #4 = H0039 #5 = H0036	Request for Pri Authorization (F Medicaid # of units per ba	PA)	# 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		
 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.		
 Bachelor's Level Community Support Staff, LPN (Individual) 							Pick a date.		
 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 (<i>Group</i>)							Pick a date.		
Total # of Units Preliminary (60 days) For Provider file Completed (180 days) Send to IME									

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

Submit to IME with page 9 and page 10, signatures completed

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	Yes. But consumer already has	Yes. Staff will work with	No. Consumer was not				
to complete a psychiatric directive	a completed psychiatric advance	consumer to develop a psychiatric	educated and asked about a				
at this time. Staff will follow up	directive.	advance directive.	psychiatric advance directive.				
during the next IRP.							
Consumer Name		Signature	Date				
Licensed Clinical Staff Team Member Name/Credentials Signature Date							
Contributing Team Member Name/Credentials Signature Date							
Contributing Team Member Name/C	Credentials	Signature	Date				
Optional Signatures: (family members, team member, etc.) Signature Date							
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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							



Consumer Name: *

Agency Name: *

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 Medicaid ID: *
Agency CSS Medicaid ID: *

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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 Medical				ner Medicaid II	D: *			
Agency Name: * Agency CSS Medicaid ID: *								
	BAND # + HCPC Code		MEDICAID ST				STATE	
Responsible Credentials In each Band	#1 = H2000 HE #2 = H2000 HE SA #3 = H2015 #4 = H0039 #5 = H0036	Request for Pric Authorization (P Medicaid # of units per ba	PA) (28	# of units approved dunits daily max sept 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 4. Bachelor's Level Community							Pick a date. Pick a date.	
Support Staff, LPN (Individual) 4. Bachelor's Level Community							Pick a date.	
Support Staff, LPN (Group) 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 (<i>Group</i>)							Pick a date.	
Total # of Units Preliminary (60 days) For Provider file Completed (180 days) Send to IME								

IRP Modification Form #2 – For New Band Submit to IME with page 6 and page 7, signatures completed

SIGNATURES AND CREDENTIALS

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to complete a psychiatric directive	a completed psychiatric advance	consumer to develop a psychiatric educated and asked abo					
at this time. Staff will follow up	directive.	advance directive. psychiatric advance directive.					
during the next IRP.			1				
Consumer Name		Signature	Date				
Licensed Clinical Staff Team Member Name/Credentials Signature Date							
Contributing Team Member Name/Credentials Signature Date							
Contributing Team Member Name/C	redentials	Signature	Date				
Optional Signatures: (family members, team member, etc.) Signature Date							
Optional Signatures: (family member	ers, 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							