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|  | **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) | | |

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

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| **Goal from CRNA:** | | | | | | | |
| Valued Life Role: | | Wellness Dimension: | | | | | |
| Strengths Related to Goal: | | | | | | | |
| **CSS Intervention(s)** | **Responsible  Credential** | | **Location of Service** | **Frequency** | **Duration** | **Band #** | **# of Units** |
| **HCPCS Code** |
| **KSR Development/Measurable Objective**  **:** | | | | | | | |
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| **KSR Development/Measurable Objective**  **:** | | | | | | | |
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| **KSR Development/Measurable Objective :** | | | | | | | |
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| **IRP Modification Form #1 – For more Units &/or New Goal**  **Submit to IME with page 3 and page 4, signatures completed** | |
| **Modifying an existing goal from the current IRP** | |
| Consumer Name: \* | Consumer Medicaid ID: \* |
| Agency Name: \* | Agency CSS Medicaid ID: \* |

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| **If this is a modification of an existing goal, please identify the Rehabilitation Goal and Objective being modified from the current IRP:** | | | | | | | |
| **Goal** | **Goal from CRNA:** | | | | | | |
| **KSR Development/Measurable Objective :** | | | | | | | |
| CSS Intervention(s) | | Responsible  Credential | Location of Service | Frequency | Duration | Band # | # of Modified  Units |
| HCPCS Code |
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| **Justification for Modification**: | | | | | | | |

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| **If this is a modification of an existing goal, please identify the Rehabilitation Goal and Objective being modified from the current IRP:** | | | | | | | |
| **Goal** | **Goal from CRNA:** | | | | | | |
| **KSR Development/Measurable Objective :** | | | | | | | |
| CSS Intervention(s) | | Responsible  Credential | Location of Service | Frequency | Duration | Band # | # of Modified  Units |
| HCPCS Code |
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| **Justification for Modification**: | | | | | | | |

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|  | **IRP Modification Form #1 – For more Units &/or New Goal**  **Submit to IME with page 3 and page 4, 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** |
| 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 | |  |  | |  |  |  | |  |

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|  | **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.** | | |

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| 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. |

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| **Consumer Name** | Signature | Date |
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| **Licensed Clinical Staff Team Member Name/Credentials** | Signature | Date |
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| Contributing Team Member Name/Credentials | Signature | Date |
|  | | |
| Contributing Team Member Name/Credentials | Signature | Date |
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| Optional Signatures: (family members, team member, etc.) | Signature | Date |
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| 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*](mailto:imecss@ubhc.rutgers.edu) *or fax (732) 235-5569;**Call us at (844) 463-2771* |

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|  | **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: \* | |

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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 # | # of  Units |
| HCPCS Code |
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| **KSR Development/Measurable Objective #2:** | | | | | | | |
| CSS Intervention(s) | Responsible  Credential | | Location of Service | Frequency | Duration | Band # | # of  Units |
| HCPCS Code |
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| **KSR Development/Measurable Objective #3:** |
| CSS Intervention(s) | Responsible  Credential | | Location of Service | Frequency | Duration | Band # | # of  Units |
| HCPCS Code |
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|  | **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** |
| 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 | |  |  | |  |  |  | |  |

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|  | **IRP Modification Form #2 – For New Band**  **Submit to IME with page 6 and page 7, signatures completed** |  |
| **SIGNATURES AND CREDENTIALS** | | |
| **The development of this Individualized Rehabilitation Plan was a consumer driven process that identifies consumer driven goals.** | | |

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| 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. |

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| **Consumer Name** | Signature | Date |
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| **Licensed Clinical Staff Team Member Name/Credentials** | Signature | Date |
|  | | |
| Contributing Team Member Name/Credentials | Signature | Date |
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| Contributing Team Member Name/Credentials | Signature | Date |
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| Optional Signatures: (family members, team member, etc.) | Signature | Date |
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| 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*](mailto:imecss@ubhc.rutgers.edu) *or fax (732) 235-5569;**Call us at (844) 463-2771* |

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