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|  | **N J Department of Human Services****Community Support Services – Individualized Rehabilitation Plan Modification** |  |
|  | **IRP Modification Form #3 – For Changing Funding Source** ***Submit to IME with Licensed Clinician’s signature*** |  |
| **Funding Change Type:** **[ ]** From Medicaid to State Funding **[ ]** From State Funding to Medicaid |
| Consumer Name: \*      | Consumer Medicaid ID*(if applicable)*: \*      |
| Agency Name: \*      | Agency CSS Medicaid ID*(if applicable)*:\*      |
| Current IRP Start date:       | Current IRP End date:       | Effective date of change:       |
| ***Has a new Enrollment Form been submitted?***  | [ ]  YES - *If yes, when:*        | [ ]  NO - *If no, please submit the updated Admission/Enrollment form together with the updated fax coversheet to indicate this funding source change* |

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|  | **BAND #** **+ HCPCs Code** | **Total Units approved on current IRP** | **Remaining Approved Units from current IRP** |
| 1. Physician, Psychiatrist

***(Maximum daily units: 8)*** | #1 = H2000 HE |       |       |
| 1. Advanced Practice Nurse

***(Maximum daily units: 12)*** | #2 = H2000 HE SA |       |       |
| 3. RN, Psychologist, Licensed Practitioner of the Healing Arts, including: Clinical Social Worker, Licensed Rehabilitation Counselor, Licensed Professional Counselor, Licensed Marriage and Family Therapist, Master’s Level Community Support Staff | #3 = H2015 |       |       |
| 4. Bachelor’s Level Community Support Staff, LPN ***(Individual)*** | #4 = H0039 |       |       |
| 4. Bachelor’s Level Community Support Staff, LPN ***(Group)*** | #4 = H0039 |       |       |
| 5. Associate’s Level Community Support Staff, High School Level Community Support Staff, Peer Level Community Support Staff ***(Individual)*** | #5 = H0036 |       |       |
| 5. Associate’s Level Community Support Staff, High School Level Community Support Staff, Peer Level Community Support Staff ***(Group)*** | #5 = H0036 |       |       |
| **Total # of units** |  |       |       |

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| **Licensed Clinical Staff Name/Credentials** | **Signature** | **Date** |
| ***Please submit this form to IME CSS via fax (732) 235-5569*** |

 **(9/2017)**