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| **COMMUNITY SUPPORT SERVICES - INDIVIDUALIZED REHABILITATION PLAN** |
|  | **N J Department of Human Services****Community Support Services – Individualized Rehabilitation Plan** |  |

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| [ ] Preliminary **(60 days)** for Provider File | [ ] Completed **(180 days)** Send to IME |
| Consumer Name: \*      |
| Date of Birth: Pick a date. | Gender: [ ] Male [ ] Female |
| Address:       |
| Diagnosis:       | Consumer Medicaid ID: \*      |
| Date of Admission: Pick a date. | Date of Last Plan: Pick a date. | Date of New Plan: Pick a date. |

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| CSS Housing Initiative: | [ ]  SPC 19GENERIC | [ ] SPC 20RIST  | [ ] SPC 21DDMI  | [ ] SPC 23MESH  | [ ] SPC 24FORENSIC | [ ] SPC 25 ESH | [ ]  SPC 26RIST/MESH | [ ] SPC 39AT RISK |
| Agency Name: \*      |
| Agency Address:       |
| Phone no.:       | Fax no.:       |
| Email:       | Agency CSS Medicaid ID: \*      |

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| ***For Official Use Only:***  |
| Medicaid:       | State Funded - State ID:       |
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| ***NOTE: The fields with an asterisk \* should autofill for the rest of the document. If not, press the “Tab” key on the keyboard.*** |

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**Community Support Services – Individualized Rehabilitation Plan**

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| **Directions**: For each Rehabilitation Goal, transfer the relevant information from the documents indicated below. First collaborate with the consumer to identify **3-4 knowledge, skill, or resource items** listed on IRP Worksheet 1 (KSR). Choose items that are either most important to work on initially, or that the person is most motivated to work on. Then use S-M-A-R-T (Specific, Measureable, Attainable, Realistic, and Timeframe) format to develop **measurable objectives** related to these areas. **Frequency**: How many times per day / week / or month. **E.g**., 3X a week. **Duration (length of service to be delivered during IRP Term)**: How many months. **E.g.** 3 months. |

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| Consumer Name: \*  | Consumer Medicaid ID: \*  |
| Agency Name: \*  | Agency CSS Medicaid ID: \*  |
| Rehabilitation Goal 1 from CRNA:       |
| Valued Life Role:       | Wellness Dimension:       |
| Strengths Related to Goal:       |
| KSR Development/Measurable Objective #1:       |
| CSS Intervention(s) | Responsible Credential | Band# | Locationof Service | Frequency | Duration | Band # | # of Units |
| HCPCS Code |
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| KSR Development/Measurable Objective #2:       |
| CSS Intervention(s) | Responsible Credential | Band# | Locationof Service | Frequency | Duration | Band # | # of Units |
| HCPCS Code |
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| KSR Development/Measurable Objective #3:       |
| CSS Intervention(s) | Responsible Credential | Band# | Locationof Service | Frequency | Duration | Band # | # of Units |
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**Community Support Services – Individualized Rehabilitation Plan**

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| Consumer Name: \*  | Consumer Medicaid ID: \*  |
| Agency Name: \*  | Agency CSS Medicaid ID: \*  |
| Rehabilitation Goal 2 from CRNA:       |
| Valued Life Role:       | Wellness Dimension:       |
| Strengths Related to Goal:       |
| KSR Development/Measurable Objective #1:       |
| CSS Intervention(s) | Responsible Credential | Band# | Locationof Service | Frequency | Duration | Band # | # of Units |
| HCPCS Code |
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| KSR Development/Measurable Objective #2:       |
| CSS Intervention(s) | Responsible Credential | Band# | Locationof Service | Frequency | Duration | Band # | # of Units |
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| KSR Development/Measurable Objective #3:       |
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**Community Support Services – Individualized Rehabilitation Plan**

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| Consumer Name: \*  | Consumer Medicaid ID: \*  |
| Agency Name: \*  | Agency CSS Medicaid ID: \*  |
| Rehabilitation Goal 3 from CRNA:       |
| Valued Life Role:       | Wellness Dimension:       |
| Strengths Related to Goal:       |
| KSR Development/Measurable Objective #1:       |
| CSS Intervention(s) | Responsible Credential | Band# | Locationof Service | Frequency | Duration | Band # | # of Units |
| HCPCS Code |
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| KSR Development/Measurable Objective #2:       |
| CSS Intervention(s) | Responsible Credential | Band# | Locationof Service | Frequency | Duration | Band # | # of Units |
| HCPCS Code |
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| KSR Development/Measurable Objective #3:       |
| CSS Intervention(s) | Responsible Credential | Band# | Locationof Service | Frequency | Duration | Band # | # of Units |
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**Community Support Services – Individualized Rehabilitation Plan**

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| Consumer Name: \*  | Consumer Medicaid ID: \*  |
| Agency Name: \*  | Agency CSS Medicaid ID: \*  |
| Rehabilitation Goal 4 from CRNA:       |
| Valued Life Role:       | Wellness Dimension:       |
| Strengths Related to Goal:       |
| KSR Development/Measurable Objective #1:       |
| CSS Intervention(s) | Responsible Credential | Band# | Locationof Service | Frequency | Duration | Band # | # of Units |
| HCPCS Code |
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| KSR Development/Measurable Objective #2:       |
| CSS Intervention(s) | Responsible Credential | Band# | Locationof Service | Frequency | Duration | Band # | # of Units |
| HCPCS Code |
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| KSR Development/Measurable Objective #3:       |
| CSS Intervention(s) | Responsible Credential | Band# | Locationof Service | Frequency | Duration | Band # | # of Units |
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**Community Support Services – Individualized Rehabilitation Plan**

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| Consumer Name: \*  | Consumer Medicaid ID: \*  |
| Agency Name: \*  | Agency CSS Medicaid ID: \*  |
| Rehabilitation Goal 5 from CRNA:       |
| Valued Life Role:       | Wellness Dimension:       |
| Strengths Related to Goal:       |
| KSR Development/Measurable Objective #1:       |
| CSS Intervention(s) | Responsible Credential | Band# | Locationof Service | Frequency | Duration | Band # | # of Units |
| HCPCS Code |
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| KSR Development/Measurable Objective #2:       |
| CSS Intervention(s) | Responsible Credential | Band# | Locationof Service | Frequency | Duration | Band # | # of Units |
| HCPCS Code |
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| KSR Development/Measurable Objective #3:       |
| CSS Intervention(s) | Responsible Credential | Band# | Locationof Service | Frequency | Duration | Band # | # of Units |
| HCPCS Code |
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**Community Support Services – Individualized Rehabilitation Plan**

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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 |       |       |       |       |       |  |

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**Community Support Services – Individualized Rehabilitation Plan**

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| **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* *or fax (732) 235-5569;**Call us at (844) 463-2771* |

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