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|  | **N J Department of Human Services**  **Community Support Services – Individualized Rehabilitation Plan Modification** |  |
|  | **IRP Modification for Additional Units**  **Submit to IME with Consumer & Licensed Clinician’s Signatures** |  |

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| Consumer Name: \* First Last | Consumer Date of Birth: \* Click or tap here to enter text. |
| Consumer Medicaid/NJMHAPP ID: \* Medicaid/NJMHAPP ID | |
| Agency Name: \* Agency Name | Agency CSS Medicaid ID: \* Agency ID |
| **Current IRP: Start Date** | **Current IRP: End Date** |

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| **Please identify the Rehabilitation Goal and Objective being modified from the current IRP:** | | | | | | | | |
| **Goal** **#** | **Goal from CRNA:** | | | | | | | |
| **Objective #** | **KSR Development/Measurable Objective:** | | | | | | | |
| **CSS Intervention(s)** | | **Location of Service** | **Frequency** | **Duration** | **Band #** | **Responsible Credential** | **HCPCS Code** | **# of Units** |
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| **Justification for Modification**: | | | | | | | | |

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| **Please identify the Rehabilitation Goal and Objective being modified from the current IRP:** | | | | | | | | |
| **Goal** **#** | **Goal from CRNA:** | | | | | | | |
| **Objective #** | **KSR Development/Measurable Objective:** | | | | | | | |
| **CSS Intervention(s)** | | **Location of Service** | **Frequency** | **Duration** | **Band #** | **Responsible Credential** | **HCPCS Code** | **# of Units** |
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| **Justification for Modification**: | | | | | | | | |

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| **Please identify the Rehabilitation Goal and Objective being modified from the current IRP:** | | | | | | | | | | | | | | | | | |
| **Goal** **#** | **Goal from CRNA:** | | | | | | | | | | | | | | | | |
| **Objective #** | **KSR Development/Measurable Objective:** | | | | | | | | | | | | | | | | |
| **CSS Intervention(s)** | | | | **Location of Service** | **Frequency** | | | | **Duration** | **Band #** | | | **Responsible Credential** | | **HCPCS Code** | | **# of Units** |
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| **Justification for Modification**: | | | | | | | | | | | | | | | | | |
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| **Responsible  Credentials**  **In each Band** | | | **HCPCS Code** | | | | | **For MEDICAID IRP only**  Request for Prior Authorization (PA)  # of units per HCPCS code | | | **For STATE IRP only**  Request for State Funded  # of units per HCPCS Code | | | | | **Modification Start Date** | | |
| **Band 1**- Physician, Psychiatrist  ***(Maximum daily units: 8)*** | | | **H2000 HE** | | | | |  | | |  | | | | | Pick a date. | | |
| **Band 2**- Advanced Practice Nurse  ***(Maximum daily units: 12)*** | | | **H2000 HE SA** | | | | |  | | |  | | | | | Pick a date. | | |
| **Band 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 | | | **H2015 HE TD** (RN)  **H2015 HE HO** (MA Licensed Clinical)  **H2015 HE** (MA No Clinical License)  **H2015 AH HE** (Licensed Psychologist) | | | | |  | | |  | | | | | Pick a date. | | |
| **Band 4**- Bachelor’s Level Community Support Staff, LPN ***(Individual)*** | | | **H0039 HN** (BA)  **H0039 TE** (Licensed LPN) | | | | |  | | |  | | | | | Pick a date. | | |
| **Band 4**- Bachelor’s Level Community Support Staff, LPN ***(Group)*** | | | **H0039 HN HQ** (BA- Group)  **H0039 HQ TE** (Licensed LPN- Group) | | | | |  | | |  | | | | | Pick a date. | | |
| **Band 5**- Associate’s Level Community Support Staff, High School Level Community Support Staff, Peer Level Community Support Staff ***(Individual)*** | | | **H0036 HM** (AA)  **H0036** (HS)  **H0036 52** (Peer) | | | | |  | | |  | | | | | Pick a date. | | |
| **Band 5**- Associate’s Level Community Support Staff, High School Level Community Support Staff, Peer Level Community Support Staff ***(Group)*** | | | **H0036 HM HQ** (AA- Group)  **H0036 HQ** (HS- Group)  **H0036 HQ 52** (Peer- Group) | | | | |  | | |  | | | | | Pick a date. | | |
| **Total # of Units** | | |  | | | | |  | | |  | | | | |  | | |
| **\*\* Please note: Each consumer may only be rendered a maximum of 28 units per day. (All bands combined.) \*\*** | | | | | | | | | | | | | | | | | | |
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| 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. | | | | | | |
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| **Consumer Name** | | | | | | | Signature | | | | | | | Date | | | |
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| **Licensed Plan Writer Name/Credentials** | | | | | | | Signature | | | | | | | Date | | | |
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| **Clinically Licensed Co-Signer Name/Credentials** (as needed) | | | | | | | Signature | | | | | | | Date | | | |
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| 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 | | | |