|  |  |  |  |
| --- | --- | --- | --- |
|  | **N J Department of Human Services**  **Community Support Services – Individualized Rehabilitation Plan Modification** | |  |
|  | **IRP Modification for a New Band or New HCPCS Code**  **Submit to IME with Consumer & Licensed Clinician’s Signatures** | |  |
| 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** | |

**New Goal**  **Existing Goal**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Rehabilitation Goal from CRNA:** | | | | | | | |
| Valued Life Role: | Wellness Dimension: | | | | | | |
| Strengths Related to Goal: | | | | | | | |
| **KSR Development/Measurable Objective #1:** | | | | | | | |
| **CSS Intervention(s)** | **Location of Service** | **Frequency** | **Duration** | **Band #** | **Responsible Credential** | **HCPCS Code** | **# of Units** |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
| **Justification for Modification**: | | | | | | | |
|  | | | | | | | |
| **KSR Development/Measurable Objective #2:** | | | | | | | |
| **CSS Intervention(s)** | **Location of Service** | **Frequency** | **Duration** | **Band #** | **Responsible Credential** | **HCPCS Code** | **# of Units** |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
| **Justification for Modification**: | | | | | | | |
|  | | | | | | | |
| **KSR Development/Measurable Objective #3:** | | | | | | | |
| **CSS Intervention(s)** | **Location of Service** | **Frequency** | **Duration** | **Band #** | **Responsible Credential** | **HCPCS Code** | **# of Units** |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
| **Justification for Modification**: | | | | | | | |
|  | | | | | | | |

**New Goal**  **Existing Goal**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Rehabilitation Goal from CRNA:** | | | | | | | |
| Valued Life Role: | Wellness Dimension: | | | | | | |
| Strengths Related to Goal: | | | | | | | |
| **KSR Development/Measurable Objective #1:** | | | | | | | |
| **CSS Intervention(s)** | **Location of Service** | **Frequency** | **Duration** | **Band #** | **Responsible Credential** | **HCPCS Code** | **# of Units** |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
| **Justification for Modification**: | | | | | | | |
|  | | | | | | | |
| **KSR Development/Measurable Objective #2:** | | | | | | | |
| **CSS Intervention(s)** | **Location of Service** | **Frequency** | **Duration** | **Band #** | **Responsible Credential** | **HCPCS Code** | **# of Units** |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
| **Justification for Modification**: | | | | | | | |
|  | | | | | | | |
| **KSR Development/Measurable Objective #3:** | | | | | | | |
| **CSS Intervention(s)** | **Location of Service** | **Frequency** | **Duration** | **Band #** | **Responsible Credential** | **HCPCS Code** | **# of Units** |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
| **Justification for Modification**: | | | | | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **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.) \*\*** | | | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 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. | | |
|  | | | | |  | |
| **Consumer Name** | | | Signature | | | Date |
|  | | | | |  | |
| **Licensed Plan Writer Name/Credentials** | | | Signature | | | Date |
|  | | | | |  | |
| **Clinically Licensed Co-signer Name/Credentials** (if necessary) | | | Signature | | | Date |
|  | | | | |  | |
| Contributing Team Member Name/Credentials | | | Signature | | | Date |
|  | | | | |  | |
| Contributing Team Member Name/Credentials | | | Signature | | | Date |
|  | | | | |  | |
| Optional Signatures: (family members, team member, etc.) | | | | Signature | | | Date |