N J Department of Human Services

Community Support Services – Individualized Rehabilitation Plan Modification

IRP Modification for a New Band

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**

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

Please send this form to UBHC IME via secure fax (732) 235-5569

IRP Modification for a New Band

Consumer Name: * First Last	Consumer Medicaid/NJMHAPP ID: * Medicaid/NJMHAPP ID
Agency Name: * Agency Name	Agency CSS Medicaid ID: * Agency ID

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

IRP Modification to a New Band

Consumer Name: * First Last			Consumer Medicaid/NJMHAPP ID: * Medicaid/NJMHAPP ID	
Agency Name: * Agency Name			Agency CSS Medicaid ID: * Agency ID	
	BAND # + HCPC Code	**For MEDICAID IRP only**	**For STATE IRP only**	
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**	**Request for State Funded # of units per band**	**IRP Start Date**
1. Physician, Psychiatrist ***(Maximum daily units: 8)***				Pick a date.
2. Advanced Practice Nurse ***(Maximum daily units: 12)***				Pick a date.
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				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.
**** 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.

First Last

Consumer Name	Signature	Date
Licensed Clinical Staff Team Member Name/Credentials	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
Optional Signatures: (family members, team member, etc.)	Signature	Date