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|  | **N J Department of Human Services****Community Support Services – Individualized Rehabilitation Plan Modification** |  |
|  | **IRP Modification Form #1 – For more Units &/or New Goal****Submit to IME with page 3 and page 4, signatures completed** |  |
| **Please check the one that apply:** **[ ]** Adding a New Goal for the current IRP (Page 1) **[ ]** Modifying an Existing Goal from the current IRP(Page 2) |

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| **[ ]  Adding a New Goal** |
| Consumer Name: \*      | Consumer Medicaid ID: \*      |
| Agency Name: \*      | Agency CSS Medicaid ID: \*      |

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| **Goal from CRNA:**       |
| Valued Life Role:       | Wellness Dimension:       |
| Strengths Related to Goal:       |
| **CSS Intervention(s)** | **Responsible Credential** | **Location of Service** | **Frequency** | **Duration** | **Band #** | **# of Units** |
| **HCPCS Code** |
| **KSR Development/Measurable Objective**  **:**       |
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| **KSR Development/Measurable Objective**  **:**       |
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| **KSR Development/Measurable Objective :**       |
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| **IRP Modification Form #1 – For more Units &/or New Goal****Submit to IME with page 3 and page 4, signatures completed** |
| **[ ]  Modifying an existing goal from the current IRP** |
| Consumer Name: \*  | Consumer Medicaid ID: \*  |
| Agency Name: \*  | Agency CSS Medicaid ID: \*  |

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| **If this is a modification of an existing goal, please identify the Rehabilitation Goal and Objective being modified from the current IRP:**  |
| **Goal**  | **Goal from CRNA:**       |
| **KSR Development/Measurable Objective :**       |
| CSS Intervention(s) | Responsible Credential | Location of Service | Frequency | Duration | Band # | # of ModifiedUnits |
| HCPCS Code |
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| **Justification for Modification**:        |

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| **If this is a modification of an existing goal, please identify the Rehabilitation Goal and Objective being modified from the current IRP:**  |
| **Goal**  | **Goal from CRNA:**       |
| **KSR Development/Measurable Objective :**       |
| CSS Intervention(s) | Responsible Credential | Location of Service | Frequency | Duration | Band # | # of ModifiedUnits |
| HCPCS Code |
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| **Justification for Modification**:        |

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|  | **IRP Modification Form #1 – For more Units &/or New Goal****Submit to IME with page 3 and page 4, signatures completed** |  |
| 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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|  | **IRP Modification Form #1 – For more Units &/or New Goal****Submit to IME with page 9 and page 10, signatures completed** |  |
| **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 |
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| 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 |

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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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|  | **N J Department of Human Services** **Community Support Services – Individualized Rehabilitation Plan Modification** |  |
|  | **IRP Modification Form #2 – For New Band****Submit to IME with page 6 and page 7, signatures completed** |  |
| Consumer Name: \*      | Consumer Medicaid ID: \*      |
| Agency Name: \*      | Agency CSS Medicaid ID: \*      |

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| **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 # | # ofUnits |
| HCPCS Code |
|       |       |       |       |       |       |       |
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| **KSR Development/Measurable Objective #2:**       |
| CSS Intervention(s) | Responsible Credential | Location of Service | Frequency | Duration | Band # | # ofUnits |
| HCPCS Code |
|       |       |       |       |       |       |       |
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| **KSR Development/Measurable Objective #3:**       |
| CSS Intervention(s) | Responsible Credential | Location of Service | Frequency | Duration | Band # | # ofUnits |
| HCPCS Code |
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|  | **IRP Modification Form #2 – For New Band****Submit to IME with page 6 and page 7, signatures completed** |  |
| 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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|  | **IRP Modification Form #2 – For New Band****Submit to IME with page 6 and page 7, signatures completed** |  |
| **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 |
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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 |
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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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