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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)** | **Responsible Credential** | **Location of Service** | **Frequency** | **Duration** | **Band #** | **# of Modified****Units** |
| **HCPCS Code** |
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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)** | **Responsible Credential** | **Location of Service** | **Frequency** | **Duration** | **Band #** | **# of Modified****Units** |
| **HCPCS Code** |
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| **Justification for Modification**:       |

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

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|  | **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: 8)*** |       |       |       | 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. |
| **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. |

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| First Last |
| **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 |
|       |
| Optional Signatures: (family members, team member, etc.) | Signature | Date |