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|  | **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** |
|       |                 |                 |                 |       |                 |                 |                 |
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| **Justification for Modification**:       |
|  |
| **KSR Development/Measurable Objective #2:**       |
| **CSS Intervention(s)** | **Location of Service** | **Frequency** | **Duration** | **Band #** | **Responsible Credential** | **HCPCS Code** | **# of Units** |
|       |                 |                 |                 |       |                 |                 |                 |
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| **Justification for Modification**:       |
|  |
| **KSR Development/Measurable Objective #3:**       |
| **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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[ ]  **New Goal** [ ]  **Existing Goal**

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