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 4 and page 5, signatures completed

Modification type : ☐ *Add a new goal to the current IRP* ☐ *Modify an existing goal from the current IRP*

Consumer Name: *	Consumer Medicaid ID: *
Consumer Date of Birth:	
Agency Name: *	Agency CSS Medicaid ID: *
Current IRP: Start date -	**Current IRP End Date -**

☐ **Add a new goal to the current IRP**

Goal from CRNA:

Valued Life Role:	Wellness Dimension:

Strengths Related to Goal:

CSS Intervention(s)	Responsible Credential	Location of Service	Frequency	Duration	Band # / HCPCS Code	# of Units
KSR Development/Measurable Objective Select One :						
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☐ **Add a new goal to the current IRP**	
Consumer Name: *	Consumer Medicaid ID: *
Consumer Date of Birth:	
Agency Name: *	Agency CSS Medicaid ID: *

Goal from CRNA:						
Valued Life Role:	Wellness Dimension:					
Strengths Related to Goal:						
CSS Intervention(s)	**Responsible Credential**	**Location of Service**	**Frequency**	**Duration**	**Band # / HCPCS Code**	**# of Units**
KSR Development/Measurable Objective Select One :						
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☐ **Modify an existing goal from the current IRP**	
Consumer Name: *	Consumer Medicaid ID: *
Consumer Date of Birth:	
Agency Name: *	Agency CSS Medicaid ID: *

If this is a modification of an existing goal, please identify the Rehabilitation Goal and Objective being modified from the current IRP:

Goal Select a no.	**Goal from CRNA:**

KSR Development/Measurable Objective Select One :

CSS Intervention(s)	Responsible Credential	Location of Service	Frequency	Duration	Band # / HCPCS Code	# of Modified Units

Justification for Modification:

If this is a modification of an existing goal, please identify the Rehabilitation Goal and Objective being modified from the current IRP:

Goal Select a no.	**Goal from CRNA:**

KSR Development/Measurable Objective Select One :

CSS Intervention(s)	Responsible Credential	Location of Service	Frequency	Duration	Band # / HCPCS Code	# of Modified Units

Justification for Modification:

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Consumer Name: *	Consumer Medicaid ID: *
Agency Name: *	Agency CSS Medicaid 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**	**Number of units approved by IME:**	**Request for State Funded # of units per band**	**Number of units approved by IME:**	**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.
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 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

Please send this form to UBHC IME UM via secure fax (732) 235-5569;
Call us at (844) 463-2771