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| **COMMUNITY SUPPORT SERVICES - INDIVIDUALIZED REHABILITATION PLAN** | | | | | |
|  | **N J Department of Human Services**  **Community Support Services – Individualized Rehabilitation Plan**  **Submit to IME with Consumer & Licensed Clinician’s Signatures** | | | |  |
| **Please check only one:**  Medicaid Funded Consumer | | | State Funded Consumer | | |
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| Preliminary **(60 days)** for Provider File | | | Completed **(180 days)** Send to IME | | |
| Consumer Name: \* First Last | | | | | |
| Date of Birth: Pick a date. | | | Gender: Male Female Transgender/Other | | |
| Address: | | | | | |
| Primary ICD-10 Diagnosis Code: | | | Consumer Medicaid/NJMHAPP ID: \* Medicaid/NJMHAPP ID | | |
| Date of CSS Admission: Pick a date. | | Date of Last Plan: Pick a date. | | Date of New Plan: Pick a date. | |

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| CSS Housing Initiative: | SPC 19  GENERIC | SPC 20  RIST | SPC 21  DDMI | SPC 23  MESH | | SPC 24  FORENSIC | SPC 25 ESH | SPC 26  RIST/MESH | SPC 39  AT RISK | |
| Agency Name: \* Agency Name | | | | | | | | | | |
| Agency Address: | | | | | | | | | | |
| Phone no.: | | | | | Fax no.: | | | | | |
| Email: | | | | | Agency CSS Medicaid ID: \* Agency ID | | | | | |
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| ***NOTE: The fields with an asterisk \* should autofill for the rest of the document. If not, press the “Tab” key on the keyboard.*** | | | | | | | | | | |
| **Directions**: Use the S-M-A-R-T (Specific, Measurable, Attainable, Realistic, and Timeframe) format to identify the consumer chosen goals. Transfer the relevant information from the Rehabilitation Needs Assessment (e.g. wellness dimension, valued life role, strengths). Collaborate with the consumer to identify **3-4 knowledge, skill, or resource (KSR) items.** Choose items that are either most important to work on initially, or that the person is most motivated to work on. Then use SMART format to develop measurable objectives related to these areas. It is important when completing the goal **and** objective sections, to describe the: **frequency**: How many times per day/week/or month. (e.g., 3X a week for 30 minutes) and **duration** (length of service to be delivered during IRP term): how many months. (e.g.2 months). | | | | | | | | | |

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| **Rehabilitation Goal 1 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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| **KSR Development/Measurable Objective #2:** | | | | | | | | |
| **CSS Intervention(s)** | **Location of Service** | | **Frequency** | **Duration** | **Band #** | **Responsible Credential** | **HCPCS Code** | **# of Units** |
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| **KSR Development/Measurable Objective #3:** | | | | | | | | |
| **CSS Intervention(s)** | **Location of Service** | | **Frequency** | **Duration** | **Band #** | **Responsible Credential** | **HCPCS Code** | **# of Units** |
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| **Rehabilitation Goal 2 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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| **KSR Development/Measurable Objective #2:** | | | | | | | | |
| **CSS Intervention(s)** | **Location of Service** | | **Frequency** | **Duration** | **Band #** | **Responsible Credential** | **HCPCS Code** | **# of Units** |
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| **KSR Development/Measurable Objective #3:** | | | | | | | | |
| **CSS Intervention(s)** | **Location of Service** | | **Frequency** | **Duration** | **Band #** | **Responsible Credential** | **HCPCS Code** | **# of Units** |
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| **Rehabilitation Goal 3 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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| **KSR Development/Measurable Objective #2:** | | | | | | | | | |
| **CSS Intervention(s)** | **Location of Service** | | **Frequency** | **Duration** | **Band #** | **Responsible Credential** | **HCPCS Code** | | **# of Units** |
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| **KSR Development/Measurable Objective #3:** | | | | | | | | | |
| **CSS Intervention(s)** | **Location of Service** | | **Frequency** | **Duration** | **Band #** | **Responsible Credential** | **HCPCS Code** | | **# of Units** |
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| **Rehabilitation Goal 4 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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| **KSR Development/Measurable Objective #2:** | | | | | | | | |
| **CSS Intervention(s)** | **Location of Service** | | **Frequency** | **Duration** | **Band #** | **Responsible Credential** | **HCPCS Code** | **# of Units** |
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| **KSR Development/Measurable Objective #3:** | | | | | | | | |
| **CSS Intervention(s)** | **Location of Service** | | **Frequency** | **Duration** | **Band #** | **Responsible Credential** | **HCPCS Code** | **# of Units** |
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| **Rehabilitation Goal 5 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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| **KSR Development/Measurable Objective #2:** | | | | | | | | |
| **CSS Intervention(s)** | **Location of Service** | | **Frequency** | **Duration** | **Band #** | **Responsible Credential** | **HCPCS Code** | **# of Units** |
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| **KSR Development/Measurable Objective #3:** | | | | | | | | |
| **CSS Intervention(s)** | **Location of Service** | | **Frequency** | **Duration** | **Band #** | **Responsible Credential** | **HCPCS Code** | **# of Units** |
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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 | **IRP 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**  Preliminary **(60 days**) For Provider file  Completed (**180 days)** Send to IME |  |  |  |  |
| **\*\* 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. | | | |
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| **Consumer Name** | | | Signature | | | Date |
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| **Licensed Plan Writer Name/Credentials** | | | Signature | | | Date |
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| **Clinically Licensed Co-Signer Name/Credentials** (as needed) | | | 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 |