



Community Support Services

Individualized Rehabilitation Plan

Please check only one:

Medicaid Funded Consumer <input type="checkbox"/>	State Funded Consumer <input type="checkbox"/>
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<input type="checkbox"/> Preliminary (60 days) for Provider File	<input type="checkbox"/> Completed (up to 180 days) Send to IME
Consumer Name: *	
Date of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgendered / Other
Address: <i>street</i> <i>apt.</i> <i>city</i> <i>state</i> <i>zip</i>	
Diagnosis:	Consumer Medicaid ID: *
Date of Admission:	Date of Last Plan: Date of New Plan:

CSS Housing Initiative:	<input type="checkbox"/> SPC 19 GENERIC	<input type="checkbox"/> SPC 20 RIST	<input type="checkbox"/> SPC 21 DDMI	<input type="checkbox"/> SPC 23 MESH	<input type="checkbox"/> SPC 24 FORENSIC	<input type="checkbox"/> SPC 25 ESH	<input type="checkbox"/> SPC 26 RIST/MESH	<input type="checkbox"/> SPC 39 AT RISK
Agency Name: *								
Agency Address: <i>street</i> <i>suite</i> <i>city</i> <i>state</i> <i>zip</i>								
Phone no.:					Fax no.:			
Email:					Agency CSS Medicaid ID: *			

NOTE: The fields with an asterisk * should autofill for the rest of the document. If not, press the "Tab" key on the keyboard.

Community Support Services – Individualized Rehabilitation Plan

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 the 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 the duration (length of service to be delivered during IRP term): how many months. (e.g., 2 months).

Consumer Name: *				Consumer Medicaid ID: *			
Agency Name: *				Agency CSS Medicaid ID: *			
Rehabilitation Goal 1 from CRNA:							
Valued Life Role:				Wellness Dimension:			
Strengths Related to Goal:							
KSR Development/Measurable Objective #1:							
CSS Intervention(s)	Responsible Credential	Band #	Location of Service	Frequency	Duration	Band #	# of Units
						HCPCS Code	
KSR Development/Measurable Objective #2:							
CSS Intervention(s)	Responsible Credential	Band #	Location of Service	Frequency	Duration	Band #	# of Units
						HCPCS Code	
KSR Development/Measurable Objective #3:							
CSS Intervention(s)	Responsible Credential	Band #	Location of Service	Frequency	Duration	Band #	# of Units
						HCPCS Code	

Community Support Services – Individualized Rehabilitation Plan

Consumer Name: *					Consumer Medicaid ID: *			
Agency Name: *					Agency CSS Medicaid ID: *			
Rehabilitation Goal 2 from CRNA:								
Valued Life Role:					Wellness Dimension:			
Strengths Related to Goal:								
KSR Development/Measurable Objective #1:								
CSS Intervention(s)	Responsible Credential	Band #	Location of Service	Frequency	Duration	Band #	# of Units	
						HCPCS Code		
KSR Development/Measurable Objective #2:								
CSS Intervention(s)	Responsible Credential	Band #	Location of Service	Frequency	Duration	Band #	# of Units	
						HCPCS Code		
KSR Development/Measurable Objective #3:								
CSS Intervention(s)	Responsible Credential	Band #	Location of Service	Frequency	Duration	Band #	# of Units	
						HCPCS Code		

Community Support Services – Individualized Rehabilitation Plan

Consumer Name: *				Consumer Medicaid ID: *			
Agency Name: *				Agency CSS Medicaid ID: *			
Rehabilitation Goal 3 from CRNA:							
Valued Life Role:				Wellness Dimension:			
Strengths Related to Goal:							
KSR Development/Measurable Objective #1:							
CSS Intervention(s)	Responsible Credential	Band #	Location of Service	Frequency	Duration	Band #	# of Units
						HCPCS Code	
KSR Development/Measurable Objective #2:							
CSS Intervention(s)	Responsible Credential	Band #	Location of Service	Frequency	Duration	Band #	# of Units
						HCPCS Code	
KSR Development/Measurable Objective #3:							
CSS Intervention(s)	Responsible Credential	Band #	Location of Service	Frequency	Duration	Band #	# of Units
						HCPCS Code	

Community Support Services – Individualized Rehabilitation Plan

Consumer Name: *				Consumer Medicaid ID: *			
Agency Name: *				Agency CSS Medicaid ID: *			
Rehabilitation Goal 4 from CRNA:							
Valued Life Role:				Wellness Dimension:			
Strengths Related to Goal:							
KSR Development/Measurable Objective #1:							
CSS Intervention(s)	Responsible Credential	Band #	Location of Service	Frequency	Duration	Band #	# of Units
						HCPCS Code	
KSR Development/Measurable Objective #2:							
CSS Intervention(s)	Responsible Credential	Band #	Location of Service	Frequency	Duration	Band #	# of Units
						HCPCS Code	
KSR Development/Measurable Objective #3:							
CSS Intervention(s)	Responsible Credential	Band #	Location of Service	Frequency	Duration	Band #	# of Units
						HCPCS Code	

Community Support Services – Individualized Rehabilitation Plan

Consumer Name: *				Consumer Medicaid ID: *			
Agency Name: *				Agency CSS Medicaid ID: *			
Rehabilitation Goal 5 from CRNA:							
Valued Life Role:				Wellness Dimension:			
Strengths Related to Goal:							
KSR Development/Measurable Objective #1:							
CSS Intervention(s)	Responsible Credential	Band #	Location of Service	Frequency	Duration	Band #	# of Units
						HCPSC Code	
KSR Development/Measurable Objective #2:							
CSS Intervention(s)	Responsible Credential	Band #	Location of Service	Frequency	Duration	Band #	# of Units
						HCPSC Code	
KSR Development/Measurable Objective #3:							
CSS Intervention(s)	Responsible Credential	Band #	Location of Service	Frequency	Duration	Band #	# of Units
						HCPSC Code	

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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 <i>(Maximum daily units: 8)</i>						
2. Advanced Practice Nurse <i>(Maximum daily units: 12)</i>						
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						
4. Bachelor’s Level Community Support Staff, LPN <i>(Individual)</i>						
4. Bachelor’s Level Community Support Staff, LPN <i>(Group)</i>						
5. Associate’s Level Community Support Staff, High School Level Community Support Staff, Peer Level Community Support Staff <i>(Individual)</i>						
5. Associate’s Level Community Support Staff, High School Level Community Support Staff, Peer Level Community Support Staff <i>(Group)</i>						
Total # of Units** <input type="checkbox"/> Preliminary (60 days) For Provider file <input type="checkbox"/> Completed (180 days) Send to IME						
** Please assure that 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?			
<input type="checkbox"/> Yes. But consumer did not wish to complete a psychiatric directive at this time. Staff will follow up during the next IRP.	<input type="checkbox"/> Yes. But consumer already has a completed psychiatric advance directive.	<input type="checkbox"/> Yes. Staff will work with consumer to develop a psychiatric advance directive.	<input type="checkbox"/> No. Consumer was not educated and asked about a psychiatric advance directive.

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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Primary Service Coordinator 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