|  |  |  |
| --- | --- | --- |
| **COMMUNITY SUPPORT SERVICES - INDIVIDUALIZED REHABILITATION PLAN** | | |
|  | **N J Department of Human Services**  **Community Support Services – Individualized Rehabilitation Plan** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Preliminary **(60 days)** for Provider File | | Completed **(180 days)** Send to IME | |
| Consumer Name: \* | | | |
| Date of Birth: Pick a date. | | Gender: Male Female | |
| Address: | | | |
| Diagnosis: | | Consumer Medicaid ID: \* | |
| Date of Admission: Pick a date. | Date of Last Plan: Pick a date. | | Date of New Plan: Pick a date. |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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 Address: | | | | | | | | | |
| Phone no.: | | | | | Fax no.: | | | | |
| Email: | | | | | Agency CSS Medicaid ID: \* | | | | |

|  |  |
| --- | --- |
| ***For Official Use Only:*** | |
| Medicaid: | State Funded - State ID: |
|  |  |
| ***NOTE: The fields with an asterisk \* should autofill for the rest of the document. If not, press the “Tab” key on the keyboard.*** | |

Page 1 of 8

**Community Support Services – Individualized Rehabilitation Plan**

|  |
| --- |
| **Directions**: For each Rehabilitation Goal, transfer the relevant information from the documents indicated below. First collaborate with the consumer to identify **3-4 knowledge, skill, or resource items** listed on IRP Worksheet 1 (KSR). Choose items that are either most important to work on initially, or that the person is most motivated to work on. Then use S-M-A-R-T (Specific, Measureable, Attainable, Realistic, and Timeframe) format to develop **measurable objectives** related to these areas. **Frequency**: How many times per day / week / or month. **E.g**., 3X a week. **Duration (length of service to be delivered during IRP Term)**: How many months. **E.g.** 3 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 |
|  |  | |  |  |  |  |  |  |
|  |
|  |  | |  |  |  |  |  |  |
|  |
|  |  | |  |  |  |  |  |  |
|  |

Page 2 of 8

**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 |
|  |  | |  |  |  |  | |  |  |
|  |
|  |  | |  |  |  |  | |  |  |
|  |
|  |  | |  |  |  |  | |  |  |
|  |

Page 3 of 8

**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 |
|  |  | |  |  |  |  | |  |  |
|  |
|  |  | |  |  |  |  | |  |  |
|  |
|  |  | |  |  |  |  | |  |  |
|  |

Page 4 of 8

**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 |
|  |  | |  |  |  |  | |  |  |
|  |
|  |  | |  |  |  |  | |  |  |
|  |
|  |  | |  |  |  |  | |  |  |
|  |

Page 5 of 8

**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 |
| 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 |
|  |  | |  |  |  |  | |  |  |
|  |
|  |  | |  |  |  |  | |  |  |
|  |
|  |  | |  |  |  |  | |  |  |
|  |

Page 6 0f 8

**Community Support Services – Individualized Rehabilitation Plan**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Consumer Name: \* | | | Consumer Medicaid ID: \* | | | | |
| Agency Name: \* | | | Agency CSS Medicaid ID: \* | | | | |
|  | **BAND #**  **+ HCPC Code** | **MEDICAID** | | | **STATE** | |  |
| **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** | | **# of units approved**  ***(28 units daily max except Band 1 & 2)*** | **Request for Prior**  **Authorization (PA)**  **State Funded**  **# of units per band** | **# of units approved**  ***(28 units daily max except Band 1 & 2)*** | **IRP Start Date** |
| 1. Physician, Psychiatrist ***(max 8 units daily)*** |  |  | |  |  |  | Pick a date. |
| 2. Advanced Practice Nurse ***(max 12 units daily)*** |  |  | |  |  |  | Pick a date. |
| 3. RN, Psychologist, Licensed Practitioner of the Health 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**  Preliminary **(60 days**) For Provider file  Completed (**180 days)** Send to IME |  |  | |  |  |  |  |

Page 7 of 8

**Community Support Services – Individualized Rehabilitation Plan**

|  |
| --- |
| **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 email at* [*imecss@ubhc.rutgers.edu*](mailto:imecss@ubhc.rutgers.edu) *or fax (732) 235-5569;**Call us at (844) 463-2771* |

Page 8 of 8