## DETERMINATION SUMMARY & PRESENTATION AND SELECTION OF SERVICE OPTIONS Please Type or Print

DHS DDPAS-10 Jan 2011		PAS AGENCY NAME:			
PERSON'S NAME:			Social Securi	y #:	
As a result of the Pre-Admissio	n Screening, it has been det not have a developmental di	termined that the individual:			
(If the individual does no	ot have a developmental disa	ability, no further determinations are	e necessary.)		
As a person with a developmer does does does does	ntal disability, the individual a not need 24-hour nursing ca not need active treatment for	also: are. r the developmental disability.			
If the individual/legal guardian is reasons for the dissatisfaction Hearings, 401 South Clinton A notice.) Assistance in the appe	dissatisfied with the determ 1 along with a copy of this venue 6 <sup>th</sup> Floor, Chicago, I als process is available upo	ination(s), he/she has the right to a form must be sent to the Illinois Illinois 60607. The documents m In request from the PAS agency. A	n appeal hearing on the matter.  Department of Healthcare and  ust be sent to that address wi  copy of this DDPAS-10 must	(To appeal, a written statement of the I Family Services, Bureau of Administrative thin sixty calendar days of the date of this be provided to the individual/legal guardian.	
Based on the above det  Nursing Facility CILA CLF	(ICF/SNF) SL	_A Hon :F/DD SQI	ne-Based Support Services	vice options, whether available or not.)	
The PAS agency has sent the i	ndividual-s referral packet to	o the individual/guardian, regardless onsibility of DHS or the PAS agency o the following service provider(s) lis	eted below:	letail that he/she is able to make an e options.	
Service Provider ————————————————————————————————————	Service	Date Referral Packet Sent	Provider-s Response		
		<del></del>			
		<del></del>			
		<del></del>			
Check here if additional ref	errals are documented on a	n attached page. All referrals must	be documented as part of the I	DDPAS-10.	
(Check if annlicable )	The individual/au	uardian chose not to meet with any	agencies to visit or discuss prod	irame	

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On (date), the individual/guardian met with the following agency	to visit or discuss the following program(s):				
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On (date), the individual/guardian met with the following agency	to visit or discuss the following program(s):				
On (date), the individual/guardian met with the following agency	to visit or discuss the following program(s):				
Check here if additional meetings or visits are documented on an attached page. All meetings or visits must be documented.					
<b>SELECTION BY INDIVIDUAL OR LEGAL GUARDIAN.</b> The PAS agency has explained to me, and I understand, each service option and the right to appeal. My selection is indicated below. This form serves as the official Notice of Determination and Selection of Service Options.					
MY CHOICE OF SERVICE OPTIONS IS:					
MY CHOICE OF SERVICE OPTIONS IS:  (Note to PAS QSP: For individuals who are eligible for the Home and Community-Based Services Waiver Services must also be completed by the individual/guardian.)					
(Note to PAS QSP: For individuals who are eligible for the Home and Community-Based Services Waiver	program, Waiver Form 1238 Choice of Supports and				
(Note to PAS QSP: For individuals who are eligible for the Home and Community-Based Services Waiver Services must also be completed by the individual/guardian.)	program, Waiver Form 1238 Choice of Supports and  DATE:  e individual/guardian who, to the best of my knowledge, al/guardian the opportunity to visit typical programs and to				

## **INSTRUCTIONS FOR COMPLETING THE DDPAS-10**

**RESULTS OF THE PRE-ADMISSION SCREENING:** Document whether the individual has a developmental disability. If so, then further document whether the individual requires (1) 24-hour nursing care and/or (2) active treatment for the developmental disability.

**RIGHT TO APPEAL**: Explain to the individual/guardian the right to appeal PAS determinations. Give a copy of the DDPAS-10 to individual/guardian. **SERVICE OPTIONS**: Regardless of availability, explain to the individual/guardian and indicate on the form the service options for which the individual is eligible. Document the date on which service options were discussed with the individual/guardian.

**<u>REFERRALS FOR SERVICES</u>**: For all referrals, document the provider, service, date referred, and provider-s response. Attach an additional page if additional space is needed. Include the individual-s name on the attached sheet and indicate that it is a continuation of the DDPAS-10.

<u>OPPORTUNITY TO VISIT PROGRAMS:</u> If the individual/guardian chose not to visit any agencies or programs, indicate this in the space provided. If the individual/guardian chose to visit or discuss one or more programs with providers, document the date, agency, and program(s) visited or discussed. If space is insufficient, indicate in the space provided that additional visits are documented on an attached sheet. Include the individual=s name on the attached sheet and indicate that it is a continuation of the DDPAS-10.

<u>CHOICE OF SERVICE OPTIONS</u> and <u>SIGNATURE</u>: The individual=s/guardian=s choice must be indicated in the space provided and the individual or guardian must sign the statement of choice. The date must be provided at the time of the signature. If the individual is eligible for Home and Community Based Services waiver programs, the PAS QSP must also assist the individual/guardian in completing Waiver Form 1238 Choice of Supports and Services. <u>SIGNATURE BY PAS QSP</u>: The PAS QSP=s signature and date confirm that the QSP has adhered to the requirements for selection and choice.itemized in the statement.