State of Illinois
Department of Human Services

DETERMINATION SUMMARY and PRESENTATION AND SELECTION OF SERVICE OPTIONS (DDPAS-10)

Please Type or Print

PAS Agency Name: _____

Individual's Name: _____ SSN _____

Results of the Pre-Admission Screening have determined that the individual ____ does ____ does not have a developmental disability. *(If the individual does not have a developmental disability, no further determinations are necessary.)*

As a person with a developmental disability, the individual also:

____ does ____ does not need 24-hour nursing care.

____ does ____ does not need active treatment for the developmental disability.

If the individual/legal guardian is dissatisfied with determinations), he/she has the right to an appeal hearing on the matter. ***(To appeal, a written statement of the reasons for the dissatisfaction along with a copy of this form must be sent to the Illinois Department of Human Services, Division of Developmental Disabilities, Medicaid Waiver Appeal, 319 E. Madison, Suite 3M, Springfield, IL 62701. The documents must be sent to that address within 60 calendar days of the date of this notice.)*** *Assistance in the appeals process is available upon request from the PAS agency.* ***A copy of this DDPAS-10 must be provided to the individual/legal guardian.***

Based on the above determinations, the individual is eligible for the following service option(s). *(Indicate all eligible service options, whether available or not.)*

_____ Nursing Facility (ICF/SNF)	_____ Intermittent CILA	_____ SLA	_____ Home-Based Support Services
_____ 24-Hour CILA	_____ Family CILA	_____ ICF/DD	_____ SODC
_____ CLF	_____ Host-Family CILA	_____ SNF/PED	_____ Other *Please specify*: _____

On _____ (date), all service options were presented to the individual/guardian, regardless of availability and in sufficient detail that he/she is able to make an informed choice. It was also explained that it is not the responsibility of DHS or the PAS agency to make the selection of service options. The PAS agency has sent the individual's referral packet to the service providers listed below:

Service Provider	Service	Date Referral Packet Sent	Provider's Response

_____ Check here if additional referrals are documented on an attached page. All referrals must be documented as part of the DDPAS-10.

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(Check if applicable) ____ The individual/guardian chose not to meet with any agencies to visit or discuss programs.

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):

____ Check here if additional meetings or visits are documented on an attached page. All meetings or visits must be documented.

SELECTION BY INDIVIDUAL OR LEGAL GUARDIAN. 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: _____ .

(Note to PAS QIDP: For individuals who are eligible for the Home and Community-Based Services Waiver program, Waiver Form 1238 Choice of Supports and Services must also be completed by the individual/guardian.)

SIGNATURE OF INDIVIDUAL OR LEGAL GUARDIAN: _____ DATE: _____

SIGNATURE OF PAS QIDP: I have explained the determinations, the options, and the right to appeal to the individual/guardian who, to the best of my knowledge, understands them. I have not recommended particular providers for services. I have offered to the individual/guardian the opportunity to visit typical programs to discuss services with providers chosen solely by the individual/guardian. The choice is made, to the best of my knowledge, without undue influence from external sources.

SIGNATURE OF PAS QIDP: _____ DATE: _____

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.

REFERRALS FOR SERVICES: 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.

OPPORTUNITY TO VISIT PROGRAMS: 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.

CHOICE OF SERVICE OPTIONS and ***SIGNATURE:*** 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 signature. If the individual is eligible for Home and Community-Based Services Waiver programs, the PAS QIDP must also assist the individual/guardian in completing Waiver Form 1238, Choice of Supports and Services.

SIGNATURE BY PAS QIDP: The PAS QIDP's signature and date confirm that the QIDP has adhered to the requirements for selection and choice itemized in the statement.