

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 developmental disability, no further determina		doesdoe	not have a developmenta	I disability. (If the individual does not have a		
As a person with a developmental disability,	the individual also:					
does does not need 24-h	our nursing care.					
does does not need activ	re treatment for the developmen	ıtal disability.				
	form must be sent to the Illinois 701. The documents must be se	Department of Hum nt to that address wi	an Services, Division of Dev thin 60 calendar days of the	relopmental Disabilities, Medicaid Waiver Appeal, e date of this notice.) Assistance in the appeals		
Based on the above determinations, the indi	vidual is eligible for the following	g service option(s). (Ir	dicate all eligible service optio	ons, whether available or not.)		
Nursing Facility (ICF/SNF)	Intermittent CILA	SLA	Hom	e-Based Support Services		
24-Hour CILA	Family CILA	ICF/DD	SOD	C		
CLF	Host-Family CILA	SNF/PED	Othe	er Please specify:		
	it is not the responsibility of DH	-		d in sufficient detail that he/she is able to make ice options. The PAS agency has sent the individual's		
Service Provider	Service	Da	e 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.



State of Illinois Department of Human Services

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(Ch	eck if applicable) The individual/guardian chose not to meet with any agencies to visit or discuss p	rograms.				
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):				
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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.)						
SIG	NATURE 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.						
SIG	NATURE OF PAS QIDP:	DATE:				
1 400	1992 (D. 12, 14) Determination Summary and Presentation and Selection of Service Ontions (DDE					



INSTRUCTIONS FOR COMPLETING THE DDPAS-10

<u>RESULTS OF THE PRE-ADMISSION SCREENING</u>: 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.

<u>RIGHT TO APPEAL</u>: 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.