Illinois PUNS
Illinois Prioritization of Urgency of Need for Services
INDIVIDUAL DATA

Effective Date (as defined in PUNS Manual (e.g., 9/09/2002): ____/____/_____

Name: First: _____ Middle Initial: _____ Last: _____

Social Security Number: _____ / _____ / _____

Reason for PUNS or PUNS Update (Check one reason only):

- ____ **New**
- ____ **Change of category (Seeking Services or Planning for Services)**
- ____ **Change of service needs (more or less) - Unchanged category (Seeking Services or Planning for Services)**
- ____ **Annual Update**
- ____ **Other, supports still needed**
- ____ **Person is fully served or is not requesting any supports within the next five (5) years**
- ____ **Moved to another state, close PUNS**
- ____ **Person withdraws, close PUNS**
- ____ **Deceased, close PUNS**
- ____ **Other, close PUNS**
- ____ **Individual Stayed in ICF/DD**
- ____ **Individual Moved to ICF/DD**
- ____ **Individual Determined Clinically Ineligible**
- ____ **Individual Determined Financially Ineligible**
- ____ **Incorrect Social Security Number**
- ____ **Unable to Locate**
- ____ **Submitted in Error**

Primary care giver, if applicable (not applicable if in residential placement):

Name: _____ Date of Birth (e.g., 07/04/1959): _____

Address: _____ City: _____ State: _____ Zip: _____

If there is a secondary care giver, list date of birth (e.g., 07/14/1959): _____

Is the individual in school? _____ Yes ____ No

If yes, what is the projected graduation date? _____

***Guardian must sign. If no guardian is appointed, individual must sign. (Both may sign).**

By signing this form, the individual/guardian acknowledges the following statements.

By signing this form, and initialing the three boxes below, the ISC acknowledges he or she has discussed and explained the following statements with the individual/guardian.

ISSUE	ISC INITIALS
Inclusion in the database does not assume eligibility for services or guarantee the receipt of services.	
This database is a waiting list for community-based services only. Individuals interested in receiving services through Intermediate Care Facilities for Persons with Developmental Disabilities (ICF/DD) can and should work with their Independent Service Coordination agency to explore potential ICF/DD providers. Individuals can still seek placement on the PUNS for waiver services while exploring the ICF/DD option.	
In the event this is the initial PUNS meeting, it should be held in person. In the event this is an annual update or a change to a PUNS record, the Independent Service Coordination agency is required to offer the opportunity for a face-to-face meeting, but at the option of the family the update or change can be completed via phone, mail, fax or email.	

Service Coordinator (Please Print Legibly): _____

(Signature) _____

Name of Agency: _____ **Phone No.** _____

***Individual Name (Please Print Legibly):** _____

(Signature) _____ **Phone No.** _____

***Guardian (Please Print Legibly):** _____

(Signature) _____ **Phone No.** _____

Other (Please Print Legibly): _____

(Signature) _____ **Phone No.** _____

All information in this form is confidential.
If your contact information changes, please promptly notify your ISC agency.
DHS Community Reporting System
CLIENT CASE REGISTRATION INFORMATION

Agency Name: _____ Agency FEIN: __ __ __ __ __ __ __ __ __

Staff completing this form: _____ Date completed: _____ Time: _____

Staff entering data from this form: _____ Date completed: _____ Time: _____

****** CLIENT DEMOGRAPHIC INFORMATION ******

CLIENT ID: __ __ __ __ __ __ __ __ __ Satellite Code: ____

First Name: _____ MI: ___ Last Name: _____ Suffix: ___

Mother's Maiden Last Name: _____SSN: __ __ __- __ __-__ __ __ __
Birth Date: __ __ /__ __ /__ __ __ __ Sex: Male / Female
Race: ___ White ___ American Indian/Alaskan Native ___ Asian
___ Black/African American ___ Native Hawaiian or Other Pacific Islander ___ Unknown

Recipient ID (RIN): __ __ __ __ __ __ __ __ __ State Operated Facility ID: __ __ __ __ __ __ __ __

Primary Language: _____

Hispanic Origin: _____ Area of Residence - County: __ __ __ Twp/CA: __ __
Medicaid Site ID: __ __ __ DHS Case ID: __ __ __ __ __ __ __ __ __ __ __
Client Address - Street: _____
City: _____ State: __ __ Zip Code: __ __ __ __ __ __ - __ __ __
Education Level: ___ ___ Employment Status: ___ ___ Marital Status: ___ ___
SSI/SSDI Eligibility: ___ ___ DFI/CFI Enrollment: ____ Citizenship: ___
Military Status: ___ Court/Forensic Treatment: ___ ___ Interpreter Services Needed: _____
Optional Data A: _____B: _____C: _____

****** GUARDIAN INFORMATION ******

#1 Guardian Type: _____
First Name: _____ MI: ___ Last Name: _____
Address: _____
City: _____ State: ___ ___ Zip: __ __ __ __ __ __ - __ __ __
Date of Appointment as Guardian: __ __ / __ __ / __ __ __ __

#2 Guardian Type: _____
First Name: _____ MI: ___ Last Name: _____
Address: _____
City: _____ ST: ___ ___ Zip: __ __ __ __ __ __ -__ __ __ __
Date of Appointment as Guardian: __ __ / __ __ / __ __ __ __

DHS Community Reporting System
CLIENT DEVELOPMENTAL DISABILITIES (DD) INFORMATION

Agency Name: _____ Agency FEIN: __ __ __ __ __ __ __ __ __

Staff completing this form: _____ Date completed: _____ Time: _____

Staff entering data from this form: _____ Date completed: _____ Time: _____

****** REGISTRATION INFORMATION ******
CLIENT ID: __ __ __ __ __ __ __ __ __
Registration Date: __ __ /__ __ / __ __ __ __ Individuals in Setting: __ __
Residential Arrangement: __ __
Area of Origin - County: __ __ __ Twp/CA: __ __ Zip Code: __ __ __ __ __ __ -__ __ __ __
****** CLINICAL INFORMATION ******
Diagnosis Codes: Code Type Code Type Code Type Type ICD-10 = A _____ ___ _____ ___ _____ ___ ICD -9 = 9 _____ ___ _____ ___ _____ ___
Age at Onset: ___ ___
ICAP/SIB - Service Score: ___ ___ Behavioral Score: ___ ___ ___ Score Type: ___
Mobility: ___
****** CLOSING INFORMATION ******
Closing Date: __ __ / __ __ / __ __ __ __ Individuals in Setting: ___ ___
Disposition: __ __ Residential Arrangement: ___ ___

For the following items indicate the reason for need by checking all that apply:

SEEKING SERVICES **(Person needs services within one year)**

___1. Individual or care giver will need support within the next year in order for the individual to continue living in their current situation.

___2. Person has a care giver (age 60+) and will need supports within the next year.

___3. Person has an ill care giver who will be unable to continue providing care within the next year.

___4. Person has behavior(s) that warrant additional supports to live in their own home or family home.

___5. Individual personal care needs cannot be met by current care givers or the person's health has deteriorated.

___6. There has been a death or other family crisis, requiring additional supports.

___7. Person has a care giver who would be unable to work if services are not provided.

___8. Person or care giver need an alternative living arrangement.

___9. Person has graduated or left school in the past 10 years,

___10. Person is living in an inappropriate place, awaiting a proper place (can manage for the short term; e.g., persons aging out of children's residential services).

___11. Person moved from another state where they were receiving residential, day and/or in-home supports.

___12. The state has plans to assist the person in moving within the next year (from a state operated Intermediate Care Facility for People with Developmental Disabilities, nursing home or state hospital).

___13. Person is losing eligibility for Department of Children and Family Services supports in the next year.

___14. Person is losing eligibility for Early Periodic Screening, Diagnosis and Treatment supports in the next year.

___15. Person is losing eligibility for Intermediate Care Facility for People with Developmental Disabilities supports in the next year.

___16. Person is losing eligibility for Medically Fragile/Technology Dependent Children's Waiver supports in the next year.

___17. Person is residing in an out-of-home residential setting and is losing funding from the public-school system.

___18. Person is losing eligibility for Individual Care Grants supports through the mental health system in the next year.

___19. Person is leaving jail, prison or other criminal justice setting in the next year.

___20. Person wants to leave current setting within the next year.

___21. Person needs services within the next year for some other reason. (Specify: _____)

PLANNING FOR SERVICES **(Person does not need services for at least a year, or the care giver is older than 60 years)**

___1. Person is not currently in need of services, but will need service if something happens to the care giver.

___2. Person lives in a large setting, and person/ family has expressed a desire to move (or the state plans to move the person**). Note: If you choose this option, please mark #8 in Seeking Services Category.**

___3. Person is dissatisfied with current residential services and wishes to move to a different residential setting.

___4. Person wishes to move to a different geographic location in Illinois.

___5. Person currently lives in out-of-home residential setting and wishes to live in own home.

___6. Person currently lives in out-of-home residential setting and wishes to return to parent's home and parents concur.

___7. Person is receiving supports for vocational or other structured activities and wants and needs increased supports to retire.

___8. Person or care giver needs increased supports.

___9. Person will be graduating in the next year.

___10. Person is losing eligibility for Department of Children and Family Services supports.

___11. Person is losing eligibility for Early Periodic Screening, Diagnosis and Treatment support.

___12. Person is losing eligibility for Technology Dependent Children's Waiver support.

___13. Person is losing eligibility for Individual Care Grants supports through the mental health system.

___14. Person is residing in an out-of-home residential setting and is losing funding from the public-school system.

___15. Other (Explain: _____)

EXISTING SUPPORTS AND SERVICES

Check the supports that are currently in place specifying whether the supports are funded by the Division of Developmental Disabilities or are Other Supports (Other Supports include Education, Early Periodic Screening, Diagnosis and Treatment, Generic, etc.).

Individual Supports	**DD Funded**	**Other Supports**
Respite Supports (24 hour)		
Respite Supports (less than 24 hours)		
Behavioral supports (includes behavioral intervention, therapy and counseling)		
Physical Therapy		
Occupational Therapy		
Speech Therapy		
Education		
Assistive Technology		
Homemaker/Chore Services		
Adaptations to Home or Vehicle		
Personal Support under a Home-Based Support Program, which could be funded by Developmental Disabilities, Division of Rehabilitation Services or Department on Aging (can include habilitation, personal care, respite, retirement supports, budgeting, etc.)		
Medical Equipment/Supplies		
Nursing Services in the Home, Provided Intermittently		
Other Individual Supports		

Transportation	**DD Funded**	**Other Supports**
Transportation (include trip/mileage reimbursement)		
Other Transportation Service		

Vocational or Other Structured Activities	**DD Funded**	**Other Supports**
Senior Adult Day Services		
Community Day Services		
Regular Work/Sheltered Employment		
Supported Employment		
Vocational and Educational Programs Funded By the Division of Rehabilitation Services		
Other Day Supports (e.g. volunteering, community experience)		

Residential Supports	**DD Funded**	**Other Supports**
Community Integrated Living Arrangement (CILA)/Family		
Community Integrated Living Arrangement (CILA)/Intermittent		
Community Integrated Living Arrangement (CILA)/Host		
Community Integrated Living Arrangement (CILA)/24 Hour		
Intermediate Care Facilities for People with Developmental Disabilities (ICF/DD) 16 or Fewer People		
Intermediate Care Facilities for People with Developmental Disabilities (ICF/DD) 17 or More People		
Medically Complex Facilities for Individuals with Developmental Disabilities (MCDD)		
State Operated Developmental Center (SODC)		
State Operated Mental Health Hospital (SOMHH)		
Supported Living Arrangement (SLA)		
Community Living Facility (CLF)		
Shelter Care/Board Home		
Nursing Home		
Assisted Living Facility		
Children's Residential Services		
Child Care Institutions (including Residential Schools)		
Children's Foster Care		
Other Residential Support (including homeless shelters) __		

SUPPORTS NEEDED

For the following items indicate if new or additional support is needed by placing a checkmark in the last column. **Leave blank if the support is not needed.**

Individual Supports **(If this section is applicable, check all that apply)**	
Personal Support (includes habilitation, personal care and intermittent respite services)	
Respite Supports (24 hours or greater)	
Behavioral Supports (includes behavioral intervention, therapy and counseling)	
Physical Therapy	
Occupational Therapy	
Speech Therapy	
Assistive Technology	
Adaptations to Home or Vehicle	
Nursing Services in the Home, Provided Intermittently	
Other Individual Supports	

Transportation **(If this section is applicable, check all that apply)**	
Transportation (include trip/mileage reimbursement)	
Other Transportation Service	

Vocational or Other Structured Activities **(If this section is applicable, check all that apply)**	
Support to work at home (e.g., self-employment or earning at home)	
Support to work in the community	
Support to engage in work/activities in a disability setting	
Attendance at activity center for seniors	

Residential Supports **(If this section is applicable, check all that apply)**	
Out-of-home residential services with less than 24-hour supports	
Out-of-home residential services with 24-hour supports	