State of Illinois
Department of Human Services

INTAKE, ASSESSMENT, & DETERMINATION SUMMARY (DDPAS-2)

PLEASE TYPE OR PRINT **PAS AGENCY NAME:** _____

Part I. ID SCREEN

Date PART I. Completed: ____ / ____ / ____

Last Name: _____ First Name: _____ Initial: _____ Social Security #: ____ / ____ / ____

Medicaid ID: _____ Referral Date: _____ Referral Source Code: _____

Time Frame: _____ Disability Indicator: _____ General Assistance: _____ SSI Referral Date: ____ / ____ / ____

Current Diagnosis: Axis I. _____

Axis II. _____

Axis III. _____

Axis IV. _____

Axis V. _____

Part II. ASSESSMENT PROCESS SUMMARY

Date PART II. Completed: ____ / ____ / ____

Disability: ____ DD ____ DD/MI ____ None Birthday: ____ / ____ / ____ Sex: _____ Race: _____ Geocode: _____

Current Setting: State-Op Fac _____ ICF/SNF _____ Shelt Care _____ ICF/DD _____ Hosp/Psych _____ Gen Hosp _____ Undomicl _____ W/Family _____

DHS Funded _____ Lives Alone _____ With Room _____ Other _____ (Explain: _____) Exceptional: _____

Date Completed	Severe Mental Illness (SMI) & (Developmental Disabilities) (DD)	Name and Title of Professional Completing the Assessment
_____	ICAP: GMI _____ AB _____ Serv. Score _____ Serv. Level _____	_____
_____	Psychological/Diagnosis (DD only)	_____
_____	Psychiatric Evaluation (SMI/DD)	_____
_____	Psychosocial Evaluation (SMI/DD)	_____
_____	Physical Examination	_____
_____	Medical History	_____
_____	Medication Review (DDPAS-3)	_____
_____	Optional Evaluation(s): _____	_____
_____	Optional Evaluation(s): _____	_____

(If additional evaluations were utilized, attach a separate page and check here: _____ .)

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Part II. (continued)

Guardian Status: The individual appears not to need a guardian. _____ The name of the individual's legal guardian is _____.
The individual was referred to GAC on _____ or to _____ (name) on _____.

Part III. **DETERMINATION & DISPOSITION SUMMARY** **Date PART III. Completed:** ____ / ____ / ____

Determination: NF Level of Care: ___Need ___No Need Active Treatment for DD: ___Need ___No Need

Date of Determination: _____ ***(Must match signature date on DDPAS-5. This date is entered as the Signature Date on the electronic OBRA-13 screen.)***

Interpretation of Data: On _____, the data developed for use in the assessment and determination of need process was shared with and interpreted to the individual, legal guardian, or others designated by the individual, in order to facilitate their participation in decisions regarding the type and setting of services to be provided.

Disposition: *Date:* _____ Type: _____Placed NF (Check One): ☐ With AT ☐ Retire from AT ☐ No Need AT

_____Home/Community Based Serv. Waiver (Check if DT only _____) _____CILA _____ICF/DD _____SNF/PED _____SODC _____Moved
_____Not Medical Eligible _____Deceased _____Withdrawn _____No Change Needed _____Other ____Convalescent Care (1st Date in NF: _____)

Name of Provider: _____

I have personally reviewed the information and data sources referenced in this document and certify that they are accurately described on this summary and that they are currently available in this record.

Signature of PAS QIDP: _____ ***Date:*** _____

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INSTRUCTIONS FOR COMPLETING PART I.

An ID Screen (OBRA 1) must be completed prior to completing PART I. **DDPAS-2 Part 1 is to be entered on the OBRA-2 Screen.**

PAS AGENCY: Enter the name of the PAS agency. ***DATE***: Enter the date (mm/dd/yyyy) on which PART I is being completed (today's date).

NAME: Enter the legal name (last, first, and middle initial) of the individual.

SOCIAL SECURITY # & MEDICAID #: Enter the individual's Social Security number and Medicaid ID number.

REFERRAL DATE/SOURCE CODE: Enter the referral date (mm/dd/yyyy) and Source Code [0=DoA, 1=DRS, 2=Psychiatric Hospital, 3=General Hospital, 4=DHS Operated Facility, 5=DHS Provider Agency, 6=Nursing Facility, 7=Individual or Family, 8=Community Social, 9=Municipal Agency (fire, police, etc.) or 10=Other].

TIME FRAME: Enter time frame as defined in Chapter 100 of the Procedures Manual (E=Emergency, P=Priority, or R=Routine). ***DISABILITY INDICATOR:*** Enter the appropriate disability indicator: 0=Reasonable basis for suspecting MI or DD. Requires further assessment; 1=Do not use this indicator; 2=Reasonable basis for suspecting MI, but individual has Alzheimer's, OBS, or dementia; 3=No reasonable basis for suspecting MI or DD. Referred to DoA or DRS for further assessment; 4=No reasonable basis for suspecting MI or DD. Referred to appropriate social service agency; 5=Indicators of need for acute psychiatric care present for an individual suspected as having a severe mental illness. Referred for psychiatric services.

GENERAL ASSISTANCE: Enter Y (yes) or N (no) to indicate whether the individual is receiving General Assistance from HFS. If yes, enter the date (mm/dd/yyyy) the individual was referred for an SSI eligibility determination. ***SSI REFERRAL DATE:*** Enter the SSI referral date (mm/dd/yyyy).

INSTRUCTIONS FOR COMPLETING PART II. (PART II is to be entered on the OBRA 7 screen.)

DISABILITY: Enter the individual's disability (DD=Developmental Disability, or None=Does not have a diagnosis of Developmental Disability).

BIRTHDAY: Enter the individual's birthday (mm/dd/yyyy). ***SEX/RACE:*** Enter the sex (M=male F=female) and race of individual. The race codes are W=White; B=Black; A=Asian; H=Hispanic; I=Indian, American; O=other. ***GEOCODE:*** Enter the 5 digit Geocode of the individual's county of origin (3 digit # for county and 2 digit # for township).

ASSESSMENT: Under the Assessment Summary Section of the PAS Manual, locate the individual's disability and enter the date completed for each of the required assessments. Further, enter the name and title of the professional for each functional and medical assessment performed. Include those assessments that are within current time frames. If the individual has a developmental disability, a diagnosis by a Psychologist is required when the individual has intellectual disability. A diagnosis by a Physician is required when the individual has Cerebral Palsy, Epilepsy, or a related condition. ***EXCEPTIONAL:*** Enter Y (yes) or N (no). This category refers to individuals who have been diagnosed with Chronic Obstructive Pulmonary Disease, dementia (all types), Huntington's Disease, Amyotrophic Lateral Sclerosis, Congestive Heart Failure, or Ventilator Dependency.

GUARDIAN: Indicate the guardianship status of the individual. If the individual has a guardian, enter the guardian's name. If the individual was referred, note the date of the referral and the person to whom the referral was made (if other than GAC). ***Note: If individual's family members are pursuing guardianship on their own, the ISC should note the date they were informed of the above.***

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INSTRUCTIONS FOR COMPLETING PART III. (PART III is to be entered on the OBRA 13 screen.)

DETERMINATION: Indicate whether the individual needs or does not need Inpatient Psych, Nursing Facility (NF) Level of Care, and Active Treatment.
DATE OF DETERMINATION: This date must match the signature date on the DDPAS-5. This date is entered as the Signature Date on the electronic OBRA-13 screen.
INTERPRETATION & DISPOSITION: Enter the date on which the data was presented to the individual, guardian, or others designated by the individual. This section may not be applicable if the individual's disposition is deceased, moved, withdrawn, or not medicaid eligible. Check the appropriate disposition. The appropriate AT disposition should be recorded for "*Placed Nursing Facility*". If the *HCBS Waiver* item is marked, check if the individual is participating only in grant-funded developmental training and is eligible for waiver coverage. HCBS Waiver must be checked if the only services are Supported Employment or Supported Living Services. "*Moved*" or "*Withdrawn*" indicates the individual moved from the PAS agency's area or withdrew in some other way prior to the completion of the Level II assessment. "*Not Medicaid Eligible*" is not to be used for individuals seeking admission to nursing facilities. All such individuals are to be screened regardless of Medicaid status. "*No Changed Needed*" should be marked for those individuals who were determined during the assessment process to require no placement or change in their current status. For "*Convalescent Care*", see Section 400.30 of the Manual. All other items should be self-explanatory. Mark only one major item and any subcategory that applies. Indicate the date of the disposition. Provide the name of the placement setting, if applicable.
SIGNATURE: Must be signed by a QIDP. Include the date. Place the original form in the individual's file, retain a copy for your files, and data enter the information into the OBRA database via the PC System. ***Determination by anyone other than a DD PAS Agency QIDP is invalid.***