IDENTIFICATION OF SERVICE NEEDS

Please Type or Print

DHS DDPAS-6
Jan 2011

PAS AGENCY NAME:_____

Person=s Name:_____ Social Security # : __ __ __/__ __/__ __ __ __

Check the following service needs that are appropriate for this individual. If checked, indicate the suggested amount of service. Provide comments as needed to assist in service planning. Needs must be identified without regard to current availability of services.

	SERVICE NEED	SUGGESTED AMOUNT AND FREQUENCY	PURPOSE/OTHER COMMENTS
	24 Hour Residential Services with 24 Hour Nursing	Not Applicable	
	24 Hour Residential Services without 24 Hour Nursing	Not Applicable	
	Intermittent Residential Services		
	Residential Service Other (Specify:)		
	Day Program Developmental Training		
	Day Program Supported Employment		
	Day Program Other (Specify:)		
	Direct Support		
	Skill Development in Activities of Daily Living		
	Social Skills Development		
	Behavioral Services		
	Psychotherapy/Counseling		
	Physical Therapy		
	Occupational Therapy		
	Medical Care (Specify:)		
	Medical Care (Specify:)		
	Speech/Communication Therapy		

CONTINUED ON PAGE 2

T	SERVICE NEED	SUGGESTED AMOUNT AND FREQUENCY	PURPOSE/OTHER COMMENTS
	Adaptive Equipment (Specify:)		
	Adaptive Equipment (Specify:)		
	Modification of Home		
	Transportation		
	Respite		
	Intensive Case Management		
	Other (Specify:)		
	Other (Specify:)		
	Other (Specify:)		
	Other (Specify:)		

___ Additional information identifying service needs is attached to this DDPAS-6.

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 QSP: _____ / ___ _____ ***(Date)***

INSTRUCTIONS FOR COMPLETING THE DDPAS-6

1. Provide the name of the PAS Agency. Provide the individual=s name and social security number.
2. Check the identified service needs as applicable. Provide individualized information that will be helpful in future service planning. Use blank lines or an additional page if additional service needs are identified. (If additional information is provided, check that it is attached.)
3. Some examples are:

Day Program Other (Specify: Senior Citizens=Program)	Daily.	To maintain social skills and motor abilities.
Psychotherapy/Counseling	Weekly.	To treat inappropriate anger and trauma.
Modification of Home	N/A	Entrance/Exit Ramps for Wheelchair.
Respite	Once weekly for four hours, year-round	Support during family errands

4. Sign and date the form as indicated.