3/06

**Ohio Department**
**of**
**Mental Retardation and Developmental Disability**

# Ohio Developmental Disability Profile (ODDP)

# Section A: Identification

(1) Name (first,middle,last)

(2) Date of Birth (month, day, year)

(3) Gender

Female ○ Male ○

(4a) County where individual lives

(4b) County where individual will receive services

(5) ODMR/DD Number

(6) Provider Contract Number (if applicable)

(7) Location where assessment administered

○ County Board office
○ Work shop
○ Individual's home
○ Other

(8) Provided information for assessment

☐ Individual
☐ Family member
☐ Advocate
☐ Provider
☐ SSA
☐ Other

(9) Programs in which the individual is now enrolled

☐ None
☐ Individual Options Waiver
☐ Residential Facility Waiver
☐ Level I Waiver
☐ Other Waiver (specify)
☐ Adult Services
☐ School/Preschool
☐ Early Intervention
☐ Other Program (specify)

# Section B: Residence Information

(10a) Individual's living arrangement

- ○ Lives alone
- ○ Lives with spouse
- ○ Lives with one parent (single, widowed, divorced)
- ○ Lives with two parents (married, domestic partners)
- ○ Lives with other family member(s) (sibling, grandparent, significant other)
- ○ Lives with 1-3 others (non-related household)
- ○ Lives with 4 or more (non-related household)

(10b) Enter the **total number** of people living in the setting who receive any MRDD services (including the individual indicated on this form)

(10c) Does the individual live with a provider? ○ Yes ○ No

(10d) If the individual lives alone, indicate the reason.

- ○ Individiual choice
- ○ Necessary for health and welfare or safety
- ○ Unknown

(10e) If the individual lives alone, could he/she reside with others? If not, indicate reason.

- ○ Yes
- ○ No

(11) Indicate any needed one-time home modifications (not currently in place).

- ☐ No modifications necessary
- ☐ Doorway modifications
- ☐ Shower installation (wheelchair accessible)
- ☐ Kitchen adaptations
- ☐ Lifts
- ☐ Ramps
- ☐ Other (please specify)

(12) Indicate any needed one-time assistive or adaptive devices (not currently in place).

- ☐ No devices necessary
- ☐ Beds
- ☐ Special chairs/car seats
- ☐ Toilets
- ☐ Eating utensils
- ☐ Hand-held shower heads
- ☐ Air conditioner / humidifier / dehumidifier
- ☐ Telecommunication device
- ☐ Wheelchairs / walkers
- ☐ Other (please specify) _____

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(13) Please indicate which of these technological devices the individual has access to in his or her **living arrangement.**

- ☐ Telephone
- ☐ Computer
- ☐ Modem (including cable modem, DSL connection)
- ☐ E-Mail
- ☐ Web browser
- ☐ Fax machine
- ☐ PDA (e.g. Palm Pilot)

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# Section C: Disability Description

(14, 15) In the left column, indicate **all** the developmental disabilities that apply. In the right column, select the **one** disability that represents the individual's **primary** developmental disability.

| Select all that apply | Select one primary | |
|---|---|---|
| ☐ | ○ | No developmental disability |
| ☐ | ○ | Mental retardation |
| ☐ | ○ | Autism |
| ☐ | ○ | Cerebral palsy |
| ☐ | ○ | Epilepsy/seizure disorder |
| ☐ | ○ | Learning disability (e.g., dyslexia, dysgraphia) |
| ☐ | ○ | Other neurological impairment(s) (e.g., Tourette's syndrome, Prader-Willi, spina bifida) |
| ☐ | ○ | Traumatic Brain Injury (TBI) |
| ☐ | ○ | Undetermined developmental disability |

(16) From the most recent assessment available, indicate the individual's level of intellectual functioning.

- ○ Normal or above
- ○ Mild retardation
- ○ Moderate retardation
- ○ Severe retardation
- ○ Profound retardation
- ○ Not determined at this time

(17) Does the individual have a psychiatric diagnosis (e.g., psychosis, personality disorder, mood disorder)?

○ Yes ○ No

# Section D: Medical Information

(18) Indicate Yes or No for **each** of these medical conditions.

| Yes | No | |
|---|---|---|
| ○ | ○ | Respiratory (e.g., asthma, emphysema, cystic fibrosis) |
| ○ | ○ | Cardiovascular (e.g., heart disease, high blood pressure) |
| ○ | ○ | Gastro-Intestinal (e.g., ulcers, colitis, liver and bowel difficulties) |
| ○ | ○ | Genito-Urinary (e.g., kidney problems) |
| ○ | ○ | Neoplastic disease (e.g., cancer, tumors) |
| ○ | ○ | Neurological diseases (e.g., MS, Tourette's, dementia, ALS, Huntington's disease) |

(19a) Does individual have a history of seizures? ○ Yes ○ No

(19b) If yes, which types of seizures has individual experienced in the **last twelve months**? (Check all that apply.)

- ☐ No seizures this year
- ☐ Simple partial (simple motor movements affected; no loss of awareness)
- ☐ Complex partial (loss of awareness)
- ☐ Generalized -- Absence (petit mal)
- ☐ Generalized -- Tonic-Clonic (grand mal)
- ☐ Had some type of seizure - not sure of type

(19c) **In the past year,** how frequently has individual experienced seizures that involve loss of awareness and/or loss of consciousness?

- ○ None during the past year
- ○ Less than once a month
- ○ About once a month
- ○ About once a week
- ○ Several times a week
- ○ Once a day or more

(20a) Indicate **all** types of **prescription** maintenance medications the individual receives on an ongoing basis. (Check all that apply.)

- ☐ No prescription medications received
- ☐ Antipsychotic, antidepressant or other medication for behavior management (e.g., Thorazine, Mellaril, Prolixin, Lithium, Elavil)
- ☐ Antianxiety agent for behavior management (e.g., Librium, Valium)
- ☐ Anticonvulsant (e.g., seizures/behavioral issues)
- ☐ Diabetes medication (oral/pump/injection)
- ☐ Other maintenance medications prescribed to treat an existing medical condition

(20b) Does the individual receive ongoing medication by injection? ○ Yes ○ No

(20c) Which best describes the level of support the individual **receives** when taking **prescription medications**?

- ○ Total support (Staff assumes total responsibility for giving individual medication; e.g., injection, in food, drops)
- ○ Assistance (Staff keeps medication and gives to individual for self-administration)
- ○ Supervision (Individual keeps own medication but needs verbal prompts from staff)
- ○ Independent (Individual is **totally** responsible for medication)

(21) Indicate the daily frequency of each procedure

| Not applicable | Once daily | Twice daily | Three or more times | All shifts | |
|---|---|---|---|---|---|
| ○ | ○ | ○ | ○ | ○ | Nasogastric/gastrostomy tube feeding |
| ○ | ○ | ○ | ○ | ○ | Parenteral therapy |
| ○ | ○ | ○ | ○ | ○ | JejunalTube |
| ○ | ○ | ○ | ○ | ○ | Tracheostomy care/suctioning |
| ○ | ○ | ○ | ○ | ○ | Wound care (wound dressings and care, ostomy dressing) |
| ○ | ○ | ○ | ○ | ○ | Oxygen and respiratory therapy (blow bottles, IPPB, respirators, suctioning and oxygen) |
| ○ | ○ | ○ | ○ | ○ | Individual fed via pump |
| ○ | ○ | ○ | ○ | ○ | Individual requires vented feeds |
| ○ | ○ | ○ | ○ | ○ | Dependent on apnea monitor, CPAP, or pulse ox |
| ○ | ○ | ○ | ○ | ○ | Individual is vent dependent |

| (22) Indicate whether any of the following medical consequences apply to the individual | Yes | No | |
|---|---|---|---|
| | ○ | ○ | Missed more than a total of two weeks of scheduled day activities or employment due to medical conditions during the past year |
| | ○ | ○ | Was hospitalized for a medical problem in the last year |
| | ○ | ○ | Presently requires direct care staff be trained in special health care procedures (e.g., ostomy care, positioning, adaptive devices, Hoyer lift) |
| | ○ | ○ | Presently requires special diet planned by licensed healthcare professional (e.g. dietician, nutritionist, nurse, etc.) |

# Section E: Sensory / Motor Information

(23) Which choice best describes the individual's hearing? (**With hearing aid** if used.)

- ○ Normal
- ○ Mild loss (frequent difficulty hearing normal speech)
- ○ Moderate loss (difficulty hearing loud speech)
- ○ Severe loss (can hear only amplified speech)
- ○ Profound loss (cannot hear even amplified speech)
- ○ Undetermined

(24) Which choice best describes the individual's vision? (**With glasses or contact lenses** if used.)

- ○ Fully sighted
- ○ Moderate impairment (has trouble seeing traffic lights, curbs, may be sensitive to bright light)
- ○ Severe impairment (cannot see faces, line on which to write or mark)
- ○ Light perception (sees only light and/or shadows)
- ○ Total blindness
- ○ Undetermined

(25) Choose the response that best describes the individual's **typical** level of mobility.

- ○ Walks independently
- ○ Walks independently but with difficulty (no corrective device)
- ○ Walks independently **with corrective device**
- ○ Walks only **with assistance from another person**
- ○ Cannot walk

(26) If the individual uses a wheelchair, select the response which best describes wheelchair (may be motorized) mobility. If the individual does not use a wheelchair, indicate this.

- ○ Individual does not use a wheelchair
- ○ Can use a wheelchair independently, including transferring
- ○ Can use a wheelchair independently with assistance in transferring
- ○ Requires assistance in transferring and moving
- ○ No mobility (must be transferred and moved)

(27) Indicate whether individual can perform each task.

| Yes | No | |
|---|---|---|
| ○ | ○ | Roll from back to stomach |
| ○ | ○ | Pull self to standing |
| ○ | ○ | Walk up and down stairs by alternating feet from step to step |
| ○ | ○ | Pick up a small object |
| ○ | ○ | Transfer an object from hand to hand |
| ○ | ○ | Mark with a pencil, crayon or chalk |
| ○ | ○ | Turn pages of a book one at a time |
| ○ | ○ | Copy a circle from an example |
| ○ | ○ | Cut with scissors along a straight line |

# Section F: Cognitive/Communication Information

(28) Indicate whether individual can perform each of these tasks.

| Yes | No | |
|---|---|---|
| ○ | ○ | Sort objects by size |
| ○ | ○ | Correctly spell first and last name |
| ○ | ○ | Tell time to the nearest five minutes (digital or analog) |
| ○ | ○ | Distinguish between right and left |
| ○ | ○ | Count ten or more objects |
| ○ | ○ | Understands simple functional signs (e.g., Exit, restrooms, stop sign) |
| ○ | ○ | Do simple addition and subtraction of figures |
| ○ | ○ | Read and comprehend simple sentences |
| ○ | ○ | Read and comprehend newspaper or magazine articles |

(29) Indicate whether the individual typically displays each of these receptive and expressive communication skills. **Method of communication can be written, oral, sign, or symbolic.**

| Yes | No | |
|---|---|---|
| ○ | ○ | Understands the meaning of 'No' |
| ○ | ○ | Understands one-step directions (e.g., 'Put on your coat.') |
| ○ | ○ | Understands two-step directions (e.g., 'Put on your coat, then go outside.') |
| ○ | ○ | Understands a joke or story |
| ○ | ○ | Indicates 'Yes' or 'No' response to a simple question |
| ○ | ○ | Asks simple questions |
| ○ | ○ | Relates experiences when asked |
| ○ | ○ | Tells a story, joke, or the plot of a television show |
| ○ | ○ | Describes realistic plans in detail |

# Section G: Behavior

(30) Indicate the frequency of **each** behavior **over the last twelve months.**

| No occurrences | Occasionally | Monthly | Weekly | Frequently | Daily | |
|---|---|---|---|---|---|---|
| ○ | ○ | ○ | ○ | ○ | ○ | Has tantrums or emotional outbursts |
| ○ | ○ | ○ | ○ | ○ | ○ | Damages own or others' property |
| ○ | ○ | ○ | ○ | ○ | ○ | Physically assaults others |
| ○ | ○ | ○ | ○ | ○ | ○ | Disrupts others' activities |
| ○ | ○ | ○ | ○ | ○ | ○ | Is verbally or gesturally abusive |
| ○ | ○ | ○ | ○ | ○ | ○ | Is self-injurious |
| ○ | ○ | ○ | ○ | ○ | ○ | Teases or harasses peers |
| ○ | ○ | ○ | ○ | ○ | ○ | Resists supervision |
| ○ | ○ | ○ | ○ | ○ | ○ | Runs or wanders away |
| ○ | ○ | ○ | ○ | ○ | ○ | Steals |
| ○ | ○ | ○ | ○ | ○ | ○ | Eats inedible objects |
| ○ | ○ | ○ | ○ | ○ | ○ | Smears feces |
| ○ | ○ | ○ | ○ | ○ | ○ | Displays sexually inappropriate behavior |
| ○ | ○ | ○ | ○ | ○ | ○ | Displays behavior of a sexually offending or predatory nature |

| **Legend** | |
|---|---|
| No occurrences | Behavior has not occurred in the last twelve months |
| Occasionally | Less than once per month |
| Monthly | About once per month |
| Weekly | About once per week |
| Frequently | Several times per week |
| Daily | Once a day or more |

(31) Indicate the frequency of each behavior **over the last twelve months.**

| No occurrences | Occasionally | Monthly | Weekly | Frequently | Daily | |
|---|---|---|---|---|---|---|
| ○ | ○ | ○ | ○ | ○ | ○ | Does not follow rules about electricity, fire, water, tools, traffic, interacting with strangers, or hazardous physical situations like broken windows or open trenches |
| ○ | ○ | ○ | ○ | ○ | ○ | Voluntary or involuntary and repetitive/disruptive occurrence of one or more of the following: body rocking, mouthing, complex hand and finger movements, thumb or limb sucking, manipulation of objects within environment, head, or arm movement, face patting, screaming, or other vocalizations, noises or clapping |
| ○ | ○ | ○ | ○ | ○ | ○ | Individual either intentionally or unintentionally threatens to do harm to self, others or objects |
| ○ | ○ | ○ | ○ | ○ | ○ | Individual displays a pattern of withdrawal, apathy or lack of energy which is not attributable to physical illness or injuries. |

| **Legend** | |
|---|---|
| No occurrences | Behavior has not occurred in the last twelve months |
| Occasionally | Less than once per month |
| Monthly | About once per month |
| Weekly | About once per week |
| Frequently | Several times per week |
| Daily | Once a day or more |

(32) **As a result of behavior problem(s),** consider whether or not each of these presently apply

| Yes | No | |
|---|---|---|
| ○ | ○ | Behavior problems currently prevent this individual from moving to a less restrictive setting |
| ○ | ○ | Specific behavioral programming or precedures are required |
| ○ | ○ | Individual's environment must be carefully structured to avoid behavior problems |
| ○ | ○ | Because of behavior problems, staff must sometimes intervene physically with individual (e.g., physically restrain individual or guide individual from room) |
| ○ | ○ | Because of behavior problems, a supervised period of time out or time away is needed at least once a week |
| ○ | ○ | Because of behavior problems, individual requires one-on-one supervision for many program activities |
| ○ | ○ | Because of behavior problems, individual has been or is involved with the criminal justice system |

# Section H: Self-Care and Daily Living Skills

(33) As best you can, indicate how independently the individual **typically** performs each activity.

| Legend | |
|---|---|
| Total support | Individual is completely dependent |
| Assistance | Individual requires lots of hands-on help |
| Supervision | Individual requires mainly verbal prompts |
| Independent | Individual starts and finishes without prompts or help |

| Total support | Assistance | Supervision | Independent | |
|---|---|---|---|---|
| ○ | ○ | ○ | ○ | Toileting/bowels |
| ○ | ○ | ○ | ○ | Toileting/bladder |
| ○ | ○ | ○ | ○ | Taking a shower or bath |
| ○ | ○ | ○ | ○ | Brushing teeth or cleaning dentures |
| ○ | ○ | ○ | ○ | Brushing and combing hair |
| ○ | ○ | ○ | ○ | Selecting clothes appropriate to weather |
| ○ | ○ | ○ | ○ | Putting on clothes |
| ○ | ○ | ○ | ○ | Undressing self |
| ○ | ○ | ○ | ○ | Drinking from a cup or glass |
| ○ | ○ | ○ | ○ | Chewing and swallowing food |
| ○ | ○ | ○ | ○ | Feeding self |
| ○ | ○ | ○ | ○ | Making bed |
| ○ | ○ | ○ | ○ | Cleaning room |
| ○ | ○ | ○ | ○ | Doing laundry |
| ○ | ○ | ○ | ○ | Using telephone |
| ○ | ○ | ○ | ○ | Shopping for a simple meal |
| ○ | ○ | ○ | ○ | Preparing foods that do not require cooking |
| ○ | ○ | ○ | ○ | Using stove or microwave |
| ○ | ○ | ○ | ○ | Crossing street in residential neighborhood |
| ○ | ○ | ○ | ○ | Using public transportation for a simple direct trip |
| ○ | ○ | ○ | ○ | Managing own money |

# Section I: Routine Voluntary Care

(34) Does the individual have a routine voluntary caregiver(s)? ○ Yes ○ No

(35) Does the individual reside with a routine voluntary caregiver(s)? ○ Yes ○ No If yes, how many days per week? ☐ day(s)

(36) What is the routine voluntary caregiver(s) approximate age and relationship to the individual?

View / edit list

If both parents or guardians provide care, do they reside together?

○ Yes ○ No

(37) What services does the routine voluntary caregiver(s) provide per week?

| None | >0-4 hours | 5-10 hours | 11-15 hours | 16-21 hours | 22-28 hours | 29+ hours | |
|---|---|---|---|---|---|---|---|
| ○ | ○ | ○ | ○ | ○ | ○ | ○ | Hygiene and grooming, dressing, bathing |
| ○ | ○ | ○ | ○ | ○ | ○ | ○ | Meal preparation |
| ○ | ○ | ○ | ○ | ○ | ○ | ○ | Eating assistance |
| ○ | ○ | ○ | ○ | ○ | ○ | ○ | Laundry, housekeeping |
| ○ | ○ | ○ | ○ | ○ | ○ | ○ | Mobility assistance |
| ○ | ○ | ○ | ○ | ○ | ○ | ○ | Shopping, money management |
| ○ | ○ | ○ | ○ | ○ | ○ | ○ | Administer medication, other medical assistance |
| ○ | ○ | ○ | ○ | ○ | ○ | ○ | Social support/companionship |
| ○ | ○ | ○ | ○ | ○ | ○ | ○ | Transportation |

(38) Based on available information, is the routine voluntary caregiver(s) **willing** to continue as a voluntary caregiver? ○ Yes ○ No ○ Cannot be determined

(39) Based on available information, is the routine voluntary caregiver(s) **able** to continue as a voluntary caregiver? ○ Yes ○ No ○ Cannot be determined

# Section J: Clinical Services

| (40) Indicate how often the individual receives services. | No occurrences | Anuually | Occasionally | Monthly | Weekly | Frequently | Daily | |
|---|---|---|---|---|---|---|---|---|
| | ○ | ○ | ○ | ○ | ○ | ○ | ○ | Psychologist |
| | ○ | ○ | ○ | ○ | ○ | ○ | ○ | Psychiatrist |
| | ○ | ○ | ○ | ○ | ○ | ○ | ○ | Speech and hearing pathologist |
| | ○ | ○ | ○ | ○ | ○ | ○ | ○ | Physical therapist |
| | ○ | ○ | ○ | ○ | ○ | ○ | ○ | Occupational therapist |
| | ○ | ○ | ○ | ○ | ○ | ○ | ○ | Physician |
| | ○ | ○ | ○ | ○ | ○ | ○ | ○ | Dentist |
| | ○ | ○ | ○ | ○ | ○ | ○ | ○ | Nurse |
| | ○ | ○ | ○ | ○ | ○ | ○ | ○ | Social worker |

| **Legend** | |
|---|---|
| No occurences | Services not required in the last twelve months |
| Annually | One time a year |
| Occasionally | Less than once per month |
| Monthly | About once per month |
| Weekly | About once per week |
| Frequently | Several times per week |
| Daily | Once a day or more |