



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
(4) 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.
- Individual 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.

- (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 conditioners / humidifier / dehumidifier
 - Telecommunication device
 - Wheelchairs / walkers
 - Other (please specify)

- (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)

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.

<p>Select all that apply. Select one primary</p> <p>No developmental disability</p> <p>Mental retardation</p> <p>Autism</p> <p>Cerebral palsy</p> <p>Epilepsy/seizure disorder</p> <p>Learning disability (e.g., dyslexia, dysgraphia)</p> <p>Other neurological impairment(s) (e.g., Tourette's syndrome, Prader-Willi, spina bifida)</p> <p>Traumatic Brain Injury (TBI)</p> <p>Undetermined developmental disability</p>	<p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p>
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(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, Effavir)
- Anxiolytic 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)

(22) Indicate whether any of the following medical consequences apply to the individual

- | | | |
|-----------------------|-----------------------|-----------------------|
| | Yes | No |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

(21) Indicate the daily frequency of each procedure	Not applicable	Once daily	Twice daily	Three or more times	All shifts
Nasogastric/gastrostomy tube feeding	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Parenteral therapy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Jejunaltube	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Tracheostomy care/suctioning	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Wound care (wound dressings and care, ostomy dressing)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Oxygen and respiratory therapy (blow bottles, IPPB, respirators, suctioning and oxygen)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Individual fed via pump	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Individual requires vented feeds	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dependent on apnea monitor, CPAP, or pulse ox	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Individual is vent dependent	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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 |
|-----------------------|-----------------------|-----------------------|
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
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| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

Section F: Cognitive/Communication Information

- (28) Indicate whether individual can perform each of these tasks.
- | | | |
|--|-----------------------|-----------------------|
| Sort objects by size | Yes | No |
| Correctly spell first and last name | <input type="radio"/> | <input type="radio"/> |
| Tell time to the nearest five minutes (digital or analog) | <input type="radio"/> | <input type="radio"/> |
| Distinguish between right and left | <input type="radio"/> | <input type="radio"/> |
| Count ten or more objects | <input type="radio"/> | <input type="radio"/> |
| Understands simple functional signs (e.g., Exit, restrooms, stop sign) | <input type="radio"/> | <input type="radio"/> |
| Do simple addition and subtraction of figures | <input type="radio"/> | <input type="radio"/> |
| Read and comprehend simple sentences | <input type="radio"/> | <input type="radio"/> |
| Read and comprehend newspaper or magazine articles | <input type="radio"/> | <input type="radio"/> |

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

Section G: Behavior

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

No occurrences	Occasionally	Monthly	Weekly	Frequency	Daily	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Has tantrums or emotional outbursts
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Damages own or others' property
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Physically assaults others
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Disrupts others' activities
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Is verbally or gesturally abusive
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Is self-injurious
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Taunts or harasses peers
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Requires supervision
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Runs or wanders away
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Steals
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Eats inedible objects
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Smears feces
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Displays sexually inappropriate behavior
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	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

Section H: Self-Care and Daily Living Skills

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

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

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

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

Legend	Total support	Assistance	Supervision	Independent	Supervision Independent
Total support: Individual is completely dependent	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Assistance: Individual requires lots of hands-on help	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Supervision: Individual requires mainly verbal prompts	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Independent: Individual starts and finishes without prompts or help	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Toileting/bowels	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Toileting/bladder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Taking a shower or bath	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Brushing teeth or cleaning dentures	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Brushing and combing hair	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Selecting clothes appropriate to weather	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Putting on clothes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Undressing self	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Drinking from a cup or glass	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Chewing and swallowing food	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feeding self	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Making bed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cleaning room	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Doing laundry	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Using telephone	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Shopping for a simple meal	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Preparing foods that do not require cooking	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Using stove or microwave	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Crossing street in residential neighborhood	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Using public transportation for a simple direct trip	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Managing own money	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

