



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) DODD 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 DD 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.

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)
-

(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.

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 | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Respiratory (e.g., asthma, emphysema, cystic fibrosis) |
| <input type="checkbox"/> | <input type="checkbox"/> | Cardiovascular (e.g., heart disease, high blood pressure) |
| <input type="checkbox"/> | <input type="checkbox"/> | Gastro-Intestinal (e.g., ulcers, colitis, liver and bowel difficulties) |
| <input type="checkbox"/> | <input type="checkbox"/> | Genito-Urinary (e.g., kidney problems) |
| <input type="checkbox"/> | <input type="checkbox"/> | Neoplastic disease (e.g., cancer, tumors) |
| <input type="checkbox"/> | <input type="checkbox"/> | 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	
	<input type="checkbox"/>	Nasogastric/gastrostomy tube Feeding				
	<input type="checkbox"/>	Parenteral therapy				
	<input type="checkbox"/>	JejunalTube				
	<input type="checkbox"/>	Tracheostomy care/suctioning				
	<input type="checkbox"/>	Wound care (wound dressings and care, ostomy dressing)				
	<input type="checkbox"/>	Oxygen and respiratory therapy (blow bottles, IPPB, respirators, suctioning and oxygen)				
	<input type="checkbox"/>	Individual fed via pump				
	<input type="checkbox"/>	Individual requires vented feeds				
	<input type="checkbox"/>	Dependent on apnea monitor, CPAP, or pulse ox				
	<input type="checkbox"/>	Individual is vent dependent				

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

- | Yes | No | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Missed more than a total of two weeks of scheduled day activities or employment due to medical conditions during the past year |
| <input type="checkbox"/> | <input type="checkbox"/> | Was hospitalized for a medical problem in the last year |
| <input type="checkbox"/> | <input type="checkbox"/> | Presently requires direct care staff be trained in special health care procedures (e.g., ostomy care, positioning, adaptive devices, Hoyer lift) |
| <input type="checkbox"/> | <input type="checkbox"/> | 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 | |
|--|--------------------------|--------------------------|--|
| | <input type="checkbox"/> | <input type="checkbox"/> | Sort objects by size |
| | <input type="checkbox"/> | <input type="checkbox"/> | Correctly spell first and last name |
| | <input type="checkbox"/> | <input type="checkbox"/> | Tell time to the nearest five minutes (digital or analog) |
| | <input type="checkbox"/> | <input type="checkbox"/> | Distinguish between right and left |
| | <input type="checkbox"/> | <input type="checkbox"/> | Count ten or more objects |
| | <input type="checkbox"/> | <input type="checkbox"/> | Understands simple functional signs (e.g., Exit, restrooms, stop sign) |
| | <input type="checkbox"/> | <input type="checkbox"/> | Do simple addition and subtraction of figures |
| | <input type="checkbox"/> | <input type="checkbox"/> | Read and comprehend simple sentences |
| | <input type="checkbox"/> | <input type="checkbox"/> | 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 | |
|--|--------------------------|--------------------------|---|
| | <input type="checkbox"/> | <input type="checkbox"/> | Understands the meaning of 'No' |
| | <input type="checkbox"/> | <input type="checkbox"/> | Understands one-step directions (e.g., 'Put on your coat.') |
| | <input type="checkbox"/> | <input type="checkbox"/> | Understands two-step directions (e.g., 'Put on your coat, then go outside') |
| | <input type="checkbox"/> | <input type="checkbox"/> | Understands a joke or story |
| | <input type="checkbox"/> | <input type="checkbox"/> | Indicates 'Yes' or 'No' response to a simple question |
| | <input type="checkbox"/> | <input type="checkbox"/> | Asks simple questions |
| | <input type="checkbox"/> | <input type="checkbox"/> | Relates experiences when asked |
| | <input type="checkbox"/> | <input type="checkbox"/> | Tells a story, joke, or the plot of a television show |
| | <input type="checkbox"/> | <input type="checkbox"/> | Describes realistic plans in detail |
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Section G: Behavior

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

No occur-ences	Occa-sionally	Monthly	Weekly	Fre-quently	Daily	
<input type="checkbox"/>	Has tantrums or emotional outbursts					
<input type="checkbox"/>	Damages own or others' property					
<input type="checkbox"/>	Physically assaults others					
<input type="checkbox"/>	Disrupts others' activities					
<input type="checkbox"/>	Is verbally or gesturally abusive					
<input type="checkbox"/>	Is self-injurious					
<input type="checkbox"/>	Teases or harasses peers					
<input type="checkbox"/>	Resists supervision					
<input type="checkbox"/>	Runs or wanders away					
<input type="checkbox"/>	Steals					
<input type="checkbox"/>	Eats inedible objects					
<input type="checkbox"/>	Smears feces					
<input type="checkbox"/>	Displays sexually inappropriate behavior					
<input type="checkbox"/>	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 occur- Occa- Monthly Weekly Fre- Daily
 ences sionally

- | | | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | 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="checkbox"/> | 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 |
| <input type="checkbox"/> | Individual either intentionally or unintentionally threatens to do harm to self, others or objects |
| <input type="checkbox"/> | 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 | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Behavior problems currently prevent this individual from moving to a less restrictive setting |
| <input type="checkbox"/> | <input type="checkbox"/> | Specific behavioral programming or procedures are required |
| <input type="checkbox"/> | <input type="checkbox"/> | Individual's environment must be carefully structured to avoid behavior problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Because of behavior problems, staff must sometimes intervene physically with individual (e.g., physically restrain individual or guide individual from room) |
| <input type="checkbox"/> | <input type="checkbox"/> | Because of behavior problems, a supervised period of time out or time away is needed at least once a week |
| <input type="checkbox"/> | <input type="checkbox"/> | Because of behavior problems, individual requires one-on-one supervision for many program activities |
| <input type="checkbox"/> | <input type="checkbox"/> | 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.

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

[View / edit list](#)

(36) What is the routine voluntary caregiver(s) approximate age and relationship to the individual? 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	
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<input type="checkbox"/>	Hygiene and grooming, dressing, bathing						
<input type="checkbox"/>	Meal preparation						
<input type="checkbox"/>	Eating assistance						
<input type="checkbox"/>	Laundry, housekeeping						
<input type="checkbox"/>	Mobility assistance						
<input type="checkbox"/>	Shopping, money management						
<input type="checkbox"/>	Administer medication, other medical assistance						
<input type="checkbox"/>	Social support/companionship						
<input type="checkbox"/>	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 occur- rences	Annually	Occa- sionally	Monthly	Weekly	Fre- Quently	Daily	
<input type="checkbox"/>	Psychologist						
<input type="checkbox"/>	Psychiatrist						
<input type="checkbox"/>	Speech and hearing pathologist						
<input type="checkbox"/>	Physical therapist						
<input type="checkbox"/>	Occupational therapist						
<input type="checkbox"/>	Physician						
<input type="checkbox"/>	Dentist						
<input type="checkbox"/>	Nurse						
<input type="checkbox"/>	Social worker						

Legend	
No occurrences	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