DIRECTIONS FOR COMPLETING THE
OHIO DEPARTMENT OF DEVELOPMENTAL DISABILITIES
LICENSED RESIDENTIAL FACILITY
VACANCY REGISTRY DATA COLLECTION FORM

This form is to be completed to ensure the ongoing accuracy of the Ohio Department of Developmental Disabilities (DODD) Licensed Residential Facility Vacancy Registry. Please complete this form whenever a vacancy becomes available and mail or fax the information to DODD. ***Please contact the Department when the vacancy is filled to ensure the information contained on the Vacancy Registry is current.***

***PLEASE PRINT OR TYPE ALL INFORMATION* (Possible electronic transmittal of form)**

ITEMS 1 THROUGH 11 ARE DEMOGRAPHIC DATA

1. **List facility name on DODD license**
2. **List facility number on DODD license(s)**
3. **List full mailing address for facility**
4. **List business phone number of facility**
5. **List county in which the facility is located**
6. **List by title or position the person to contact concerning the vacancy**
7. **Identify facility type (ICF/MR or Waiver)**
8. **List facility capacity on license**
9. **List the number of vacancies in the facility**
10. **Identify the date the vacancy(ies) became (will become) available**

ITEM 11 IS A RESIDENT'S PROFILE

11. **Check all characteristics of residents who can be accommodated in the facility**

ITEM 12 IS THE FACILITY'S PROFILE

12. **Check all available facility services**

GENERAL COMMENT(S) is to be completed with a brief summary of any additional information that the facility would like to share including, but not limited to, the facility's mission statement.

PLEASE RETURN THIS FORM TO:

OHIO DEPARTMENT OF DEVELOPMENTAL DISABILITIES, COMMUNITY SERVICES
LICENSED RESIDENTIAL FACILITY VACANCY REGISTRY
1810 SULLIVANT AVENUE
COLUMBUS, OHIO 43222

OR FAX TO (614) 644-6676

PLEASE NOTE: THE VACANCY REGISTRY IS FOR FACILITIES LICENSED BY THE OHIO DEPARTMENT OF DEVELOPMENTAL DISABILITIES ONLY.

OHIO DEPARTMENT OF DEVELOPMENTAL DISABILITIES
LICENSED RESIDENTIAL FACILITY VACANCY REGISTRY
DATA COLLECTION FORM
(Refer to directions before completing)
Please Duplicate Form

1. _____ 2. _____
Facility Name DODD Facility Number

3. _____
Address City State Zip

4. (____)_____ 5. _____ 6. _____
Telephone number County Contact Person

7. Facility Type: ICF/MR _____ Waiver _____ Other (describe)_____

8. _____ 9. _____
Licensed Capacity Number of Vacancies

10. _____
Date Vacancy Available

11. RESIDENT'S PROFILE:

__ male
__ female
__ 0-3 years old
__ 4-22 years old
__ 23 to 60 years old
__ 61 years old and up
__ medically fragile
__ TBI (traumatic brain injury)
__ CP (cerebral palsy)
__ ambulatory
__ non-ambulatory
__ autism
__ MRO (mentally retarded offender)
__ dual diagnosis
__ Prader-Willie syndrome
__ hearing impaired
__ visually impaired
__ moderate retardation
__ severe retardation
__ profound retardation
__ behaviorally challenged
__ other (describe)_____

12. FACILITY PROFILE:

Staffing:

__ nursing services
__ nutritional services
__ social service staff
__ ancillary staff: __ OT; __ PT; __ Speech; __ Psychology
__ other (describe): _____

Physical Facility:

Maximum number of persons sharing bedroom:_____

__ single floor dwelling
__ multiple floor dwelling
__ wheelchair accessible

General Comments: _____
_____
_____

Completed By:

Name: _____ Title:_____ Date: _____

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