



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

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**Ohio Developmental Disability Profile (ODDP)**



## Section B: Residence Information

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(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.

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

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(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

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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

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

Yes No

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## Section D: Medical Information

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(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)		

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(19a) Does individual have a history of seizures?

	Yes	No
(19b) If yes, which types of seizures has individual experienced in the <b>last twelve months</b> ? (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) <b>In the past year</b> , 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

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(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

Jejunum Tube

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.)

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## Section E: Sensory / Motor Information

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(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)
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(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

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## Section F: Cognitive/Communication Information

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(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

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(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

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## Section G: Behavior

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

No occur-    Occa-    Monthly    Weekly    Fre-    Daily  
 rrences    sionally

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

<b>Legend</b>	
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  
 rrences    sionally

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.

<b>Legend</b>	
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 procedures 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

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

Total support Assistance Supervision Independent

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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

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

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## Section I: Routine Voluntary Care

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

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

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(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

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(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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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

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

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

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## Section J: Clinical Services

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(40) Indicate how often the individual receives services.

No occurrences      Annuually      Occa- sionally      Monthly      Weekly      Fre- quently      Daily

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Psychologist

Psychiatrist

Speech and hearing pathologist

Physical therapist

Occupational therapist

Physician

Dentist

Nurse

Social worker

<b>Legend</b>	
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

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