NYS Office For People With Developmental Disabilities

Putting People First

DEVELOPMENTAL DISABILITIES PROFILE

Fill in the Blanks or Circle the Appropriate Number(s) for Each Item

A. IDENTIFICATION

1. Date Completed MO. | DAY | YR.

2. TABS I.D.

3. Agency/Program Name _____

4. Agency/Program Code

5. Print the individual's last name, first name, and middle initial.

LAST | FIRST | MI

6. Birthdate MO. | DAY | YR.

7. Sex: 1 Male 2 Female

8. Indicate individual's place of residence:

1 Living independently
2 Living with relatives
3 OPWDD Certified Residence
4 Health Facility (SNF, HRF, NH)
5 Other (*specify*) _____

9. Mark the day programs in which individual is now enrolled for a **minimum of one-half day**:

1 None
2 OPWDD Cert./Funded Program
3 School
4 Competitive Employment
5 Other (*specify*) _____

B. DISABILITY DESCRIPTION

10. Circle **all** the developmental disabilities that apply:

1 No developmental disability
2 Mental Retardation
3 Autism
4 Cerebral palsy
5 Epilepsy/Seizure disorder
6 Learning disability (e.g., dyslexia, dysgraphia)
7 Other neurological impairment(s) (e.g., Tourette's Syndrome, Prader-Willi)
8 Undetermined developmental disability

11. From the developmental disabilities circled in Question 10, **enter the number** (1 through 8) of the **one** developmental disability that best applies:

Primary Developmental Disability Number =

B. DISABILITY DESCRIPTION (cont.)

12. From the most recent assessment available, indicate individual's level of intellectual functioning:

1 Normal or above
2 Mild retardation
3 Moderate retardation
4 Severe retardation
5 Profound retardation
6 Not determined at this time

13. Does individual have a psychiatric diagnosis (e.g., psychosis, personality disorder, neurosis)?

1 Yes 2 No

C. MEDICAL

14. Indicate YES or NO for **each** of the following medical conditions:

	YES	NO
a. Respiratory (e.g., asthma, emphysema, cystic fibrosis).....	1	2
b. Cardiovascular (e.g., heart disease, high blood pressure) …….....	1	2
c. Gastro-Intestinal (e.g., ulcers, colitis, liver and bowel difficulties) ..	1	2
d. Genito-Urinary (e.g., kidney problems) ….....	1	2
e. Neoplastic Disease (e.g., cancer, tumors) ……	1	2
f. Neurological Diseases (e.g., MS, Organic Brain Syndrome, ALS, Huntington's Disease) ……	1	2

15. a. Does individual have a history of seizures?

1 Yes (Answer Questions 15b and 15c)
2 No (Skip to Question 16a)

b. Which types of seizures has individual experienced in the **last twelve months**? (Circle **all** that apply.)

1 No seizures this year (Skip to Question 16a)
2 Simple partial (Simple motor movements affected; No loss of awareness)
3 Complex partial (Loss of awareness)
4 Generalized – Absence (Petit Mal)
5 Generalized – Tonic-Clonic (Grand Mal)
6 Had some type of seizure – not sure of type

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

1 None during past year
2 Less than once a month
3 About once a month
4 About once a week
5 Several times a week
6 Once a day or more

C. MEDICAL (cont.)

16. a. Indicate **all** types of **prescription** medications the individual receives on an **ongoing** basis?

1 No prescription medications (Skip to Question 17)

2 Antipsychotic or antidepressant for behavior management (e.g., Thorazine, Mellaril, Prolixin, Lithium, Elavil)

3 Antianxiety agent for behavior management (e.g., Librium, Valium)

4 Anticonvulsant

5 Diabetes medication

6 Other maintenance medications prescribed to treat an existing medical condition

b. Does individual receive ongoing medication by injection?

1 Yes 2 No

c. Which best describes the level of support individual **receives** at this program when taking **prescription** medications?

1 No medications received at this program

2 Total support (Staff assumes **total** responsibility for giving individual medication, e.g., injection, in food, drops)

3 Assistance (Staff keeps medication and gives to individual for self administration)

4 Supervision (Individual keeps own medication but needs verbal prompts from staff)

5 Independent (Individual is **totally** responsible for medication)

17. Indicate whether or not individual:

	YES	NO
a. Missed more than a total of two weeks of day programming due to medical conditions during the last year ……..…..	1	2
b. Was hospitalized for medical problem in the last year .	1	2
c. Presently requires direct care staff be trained in special health care procedures (e.g., ostomy care, positioning, adaptive devices) ……	1	2
d. Presently requires special diet planned by dietician, nutritionist, or nurse (e.g., high fiber, low calorie, low sodium, pureed).....	1	2

D. SENSORY / MOTOR (cont.)

20. Circle the response that best describes individual's **typical** level of mobility. (Indicate the **one** that best applies):

1 Walks independently

2 Walks independently but with difficulty

3 Walks independently **with corrective device**

4 Walks only **with assistance from another person**

5 Can not walk

21. a. Does individual use a wheelchair?

1 Yes (Answer Question 21b)

2 No (Skip to Question 22)

b. Mark the **one** response that best describes wheelchair (may be motorized) mobility:

1 Can use wheelchair independently, including transferring

2 Can use wheelchair independently with assistance in transferring

3 Requires assistance in transferring and moving

4 No mobility – must be transferred and moved

22. Indicate whether or not individual:

	YES	NO
a. Can roll from back to stomach …….....…..	1	2
b. Can pull self to standing …….….…..	1	2
c. Can walk up and down stairs by alternating feet from step to step …….….	1	2
d. Can pick up a small object …….....	1	2
e. Can transfer an object from hand to hand ….....	1	2
f. Can mark with pencil, crayon or chalk ..…….….	1	2
g. Can turn pages of a book one at a time ……	1	2
h. Can copy a circle from an example…….....	1	2
i. Cut with scissors along a straight line…….….....	1	2

D. SENSORY / MOTOR

18. Which alternative best describes individual's hearing? **(With hearing aid if used)**

1 Normal

2 Mild loss (frequent difficulty hearing normal speech)

3 Moderate loss (difficulty hearing loud speech)

4 Severe loss (can hear **only** amplified speech)

5 Profound loss (can not hear even amplified speech)

6 Undetermined

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

1 Fully sighted

2 Moderate impairment (has trouble seeing traffic lights, curbs, may be sensitive to bright light)

3 Severe impairment (cannot see faces, line on which to write or mark)

4 Light perception (sees only light and/or shadows)

5 Total blindness

6 Undetermined

E. COGNITIVE / COMMUNICATION

23. Indicate whether or not individual can perform each of the following:

	YES	NO
a. Sort objects by size…….…….…...….	1	2
b. Correctly spell first and last name.……..	1	2
c. Tell time to nearest five minutes (digital or analog)…	1	2
d. Distinguish between right and left.…….....	1	2
e. Count ten or more objects…….…..….....	1	2
f. Understand simple functional signs (e.g., EXIT, restrooms)……....…..……....	1	2
g. Do simple addition and subtraction of figures..……	1	2
h. Read and comprehend simple sentences…….....	1	2
i. Read and comprehend newspaper or magazine articles….…….....	1	2

E. COGNITIVE / COMMUNICATION (cont.)

24. Indicate whether or not individual **typically** displays each of the following receptive and expressive communications skills. **Method of communication can be written, verbal, sign, or symbolic**.

	YES	NO
a. Understands the meaning of 'No'	1	2
b. Understands one-step directions (e.g., "Put on your coat.")	1	2
c. Understands two-step directions (e.g., "Put on your coat, then go outside.")	1	2
d. Understands a joke or story	1	2
e. Indicates a 'Yes' or 'No' response to a simple question	1	2
f. Asks a simple question	1	2
g. Relates experiences when asked	1	2
h. Tells a story, joke, or the plot of a television show	1	2
i. Describes realistic plans in detail	1	2

F. BEHAVIOR

25. Indicate the frequency of **each** behavior **over the last twelve months** at **this** program:

	NOT THIS YEAR	OCCASIONALLY *Less than once a month*	MONTHLY *About once a month*	WEEKLY *About once a week*	FREQUENTLY *Several times a week*	DAILY *Once a day or more*
a. Has tantrums or emotional outbursts	1	2	3	4	5	6
b. Damages own or others' property	1	2	3	4	5	6
c. Physically assaults others	1	2	3	4	5	6
d. Disrupts others' activities	1	2	3	4	5	6
e. Is verbally or gesturally abusive	1	2	3	4	5	6
f. Is self-injurious	1	2	3	4	5	6
g Teases or harasses peers	1	2	3	4	5	6
h. Resists supervision	1	2	3	4	5	6
i. Runs or wanders away	1	2	3	4	5	6
j. Steals	1	2	3	4	5	6
k. Eats inedible objects	1	2	3	4	5	6
l. Displays sexually inappropriate behavior	1	2	3	4	5	6
m. Smears feces	1	2	3	4	5	6

26. As a result of any behavior problem(s) in **this** program, consider whether or not **each** of the following **presently** apply:

	YES	NO
a. Behavior problems currently prevent this individual from moving to a less restrictive setting.	1	2
b. Specific behavioral programming or procedures are required	1	2
c. Individual's environment must be carefully structured to avoid behavior problems	1	2
d. Because of behavior problems, staff must sometimes intervene physically with individual (e.g., physically restrain individual or guide individual from room)	1	2
e. Because of behavior problems, a supervised "time-out" period is needed at least once a week	1	2
f. Because of behavior problems, individual requires one-on-one supervision for many program activities..	1	2

G. SELF-CARE / DAILY LIVING SKILLS

27. As best you can, indicate how **independently** individual **typically** performs each activity:	TOTAL SUPPORT *Completely Dependent*	ASSISTANCE *Requires **lots** of hands-on help*	SUPERVISION *Requires **mainly** verbal prompts*	INDEPENDENT *Starts and finishes without prompts or help*
a. Toileting/bowels ……	1	2	3	4
b. Toileting/bladder ……..	1	2	3	4
c. Taking a shower/bath…….	1	2	3	4
d. Brushing teeth/cleaning dentures …….	1	2	3	4
e. Brushing/combing hair ……..	1	2	3	4
f. Selecting clothes appropriate to weather ……..	1	2	3	4
g Putting on clothes……..	1	2	3	4
h. Undressing self …….	1	2	3	4
i. Drinking from a cup or glass ……..…….	1	2	3	4
j. Chewing and swallowing food……..	1	2	3	4
k. Feeding self ……	1	2	3	4

28. As best you can, indicate how **independently** individual **typically** performs each activity:	TOTAL SUPPORT *Completely Dependent*	ASSISTANCE *Requires **lots** of hands-on help*	SUPERVISION *Requires **mainly** verbal prompts*	INDEPENDENT *Starts and finishes without prompts or help*
a. Making bed ……	1	2	3	4
b. Cleaning room ……	1	2	3	4
c. Doing laundry ……	1	2	3	4
d. Using telephone …….	1	2	3	4
e. Shopping for a simple meal ……	1	2	3	4
f. Preparing foods that do not require cooking ...……	1	2	3	4
g. Using stove or microwave …..……	1	2	3	4
h. Crossing street in residential neighborhood……	1	2	3	4
i. Using public transportation for a simple direct trip ……	1	2	3	4
j. Managing own money……. ……	1	2	3	4

H. CLINICAL SERVICES

29. Indicate how often individual receives services from the following clinical specialists **provided or funded by this program**:	NOT THIS YEAR	OCCASIONALLY *Less than once a month*	MONTHLY *About once a month*	WEEKLY *About once a week*	FREQUENTLY *Several times a week*	DAILY *Once a day or more*
a. Psychologist…….	1	2	3	4	5	6
b. Psychiatrist…….....…..	1	2	3	4	5	6
c. Speech and Hearing Pathologist……..	1	2	3	4	5	6
d. Physical Therapist.....	1	2	3	4	5	6
e. Occupational Therapist…….	1	2	3	4	5	6
f. Physician…….……..	1	2	3	4	5	6
g Nurse ……	1	2	3	4	5	6
h. Social Worker……	1	2	3	4	5	6

COMPLETED BY:	TELEPHONE NO. ( )