



Office for People With Developmental Disabilities

DDP-1 (10/16)

DEVELOPMENTAL DISABILITIES PROFILE REGISTRATION / MOVEMENT FORM

Fill out items 1 through 7, and 18 including "completed by" and "phone number" on every DDP-1. Complete other items as required.

1. PURPOSE:											
<input type="checkbox"/> 1 Demographic Data Change				<input type="checkbox"/> 3 Moved Out of State				<input type="checkbox"/> 5 Died			
<input type="checkbox"/> 2 Add				<input type="checkbox"/> 4 Remove				<input type="checkbox"/> 6 Transferred within agency			
2. TABS ID (if known):											
3. LAST NAME:								FIRST:		MI:	
4. SEX: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE											
5. BIRTH DATE						MO		DAY		YR	
6. COUNTY OF RESIDENCE:											
7. AGENCY NAME:						PROGRAM NAME:					
8. REMOVE PROGRAM CODE						9 ADD PROGRAM CODE:					
10 REMOVE/ADD DATE		MO		DAY		YR					
11 RESIDENTIAL ADDRESS: (Please print)											
c/o											
NAME											
STREET											
CITY						STATE			ZIP		
12. INDIVIDUAL'S RESIDENCE TYPE: (mark only one)											
<input type="checkbox"/> 1 Alone				<input type="checkbox"/> 4 Department of Social Services Residence or Foster Care Home				<input type="checkbox"/> 7 OPWDD / Agency Operated Residence			
<input type="checkbox"/> 2 With Friends / Housemates				<input type="checkbox"/> 5 Nursing Facility				<input type="checkbox"/> 8 Other			
<input type="checkbox"/> 3 With Member of His / Her Own Family				<input type="checkbox"/> 6 Homeless or Shelter							
13. SOCIAL SECURITY NUMBER:						14. PERSON'S MEDICAID NUMBER (CIN):					
15. ETHNICITY / RACE:											
<input type="checkbox"/> 1 White				<input type="checkbox"/> 3 Hispanic				<input type="checkbox"/> 5 American Indian / Alaskan			
<input type="checkbox"/> 2 Black				<input type="checkbox"/> 4 Asian or Pacific Islander				<input type="checkbox"/> 6 Other			
16. DISABILITIES: Indicate "1" for Primary (mark only one) and "2" for All Other Disabilities: (mark as many as apply)											
<input type="checkbox"/> 1 Developmental Delay				<input type="checkbox"/> 8 Psychiatric Disorder				<input type="checkbox"/> 15 Fetal Alcohol Syndrome			
<input type="checkbox"/> 2 Intellectual Disability				<input type="checkbox"/> 9 Chronic Physical / Medical Condition				<input type="checkbox"/> 16 Narcolepsy			
<input type="checkbox"/> 3 Autism Spectrum Disorder				<input type="checkbox"/> 10 Sensory Impairment				<input type="checkbox"/> 17 Neurofibromatosis			
<input type="checkbox"/> 4 Cerebral Palsy				<input type="checkbox"/> 11 Undetermined				<input type="checkbox"/> 19 Spina Bifida			
<input type="checkbox"/> 5 Epilepsy / Seizure Disorder				<input type="checkbox"/> 12 Other (specify): _____				<input type="checkbox"/> 20 Tourette Syndrome			
<input type="checkbox"/> 6 Learning Disorder				<input type="checkbox"/> 13 Traumatic Brain Injury (TBI)				<input type="checkbox"/> 21 Toxic Substance Exposure			
<input type="checkbox"/> 7 Other Neurological Impairment				<input type="checkbox"/> 14 Prader-Willi Syndrome (PWS)				<input type="checkbox"/> 22 Child under 5 unable to diagnose			
17. PREFERRED LANGUAGE:											
Spoken				Nonverbal				Understood			
<input type="checkbox"/> 1 English				<input type="checkbox"/> 1 Sign				<input type="checkbox"/> 1 English			
<input type="checkbox"/> 2 Spanish				<input type="checkbox"/> 2 Other Symbolic				<input type="checkbox"/> 2 Spanish			
<input type="checkbox"/> 97 None				<input type="checkbox"/> 97 None				<input type="checkbox"/> 97 None			
<input type="checkbox"/> 98 Other: _____				<input type="checkbox"/> 98 Other: _____				<input type="checkbox"/> 98 Other: _____			
18. COMPLETED BY: (Print staff name)				DATE COMPLETED				PHONE NUMBER			
_____				/ /				()			

The DDP-1 is to be completed by all voluntary agency OPWDD-certified or funded programs or services. Private schools may use either form DDP-1 or OMR 725.

GENERAL INSTRUCTIONS:

Items 1-7, and 18 should **always** be completed.

Complete items 8 and 10 if a person is leaving a program or 9 and 10 if a person is entering a program.

Complete items 8, 9, and 10 if purpose #6, Transferred within agency, is marked.

Complete items 11-17 for anyone new to your agency, for anyone not previously registered in TABS, or if there is a question about whether a person has been previously registered in TABS.

1. Purpose:

- 1 Select this response if information on a **previous** form should be updated or corrected.
- 2 A person is added to a residence on the first day he/she sleeps in the residence. A person is added to a day program/service on the first day he/she receives services.
- 4 If a person is leaving more than one program within the agency, each program must report the removal of that person from its rolls.
- 5 The date of the person's death should be entered in item 10, *Remove/Add Date*.
- 6 Select this response if a person is changing programs (such as a residence) within the same agency. Complete items 8, 9 and 10 if this purpose is chosen.

2. TABS ID:

The minimum information required to register a person in TABS is the person's name, sex, date of birth, and county of residence. This number may be up to 6 digits in length.

3. Name & 5. Date of Birth:

For each of these items, use the person's birth certificate as the preferred source of the information. If not available, use the information as it appears on the person's Medicaid card.

6. County of Residence:

This is the name of the county where the person resides. If adding this person to a residential program, use the name of the county where the residence is located.

8. & 9. Program Code (Remove & Add):

The Program code is an eight (8) digit number used to identify the program or service in TABS. Please contact the DDP Coordinator in your area if you are unsure of the correct code to use.

10. Remove/Add Date:

Enter the date of the event for choice 2-6 in item 1, *Purpose*. Enter a date if choice 1, *Demographic Data Change*, involves a change of address.

16. Disabilities:

Any disability indicated in this item should be officially documented in the person's record including the signature of the diagnosing physician/psychologist/clinician.

17. Preferred Language:

Indicate which method of communication the person **prefers** to use.

18. Completed by:

This should contain the name and phone number (including area code) of the **staff** person who has completed this form. *Please do not ask a parent, guardian or friend to complete the DDP-1.*

If you have other questions about any item on the DDP-1, please consult the Users Guide.
Copies of the Guide may be obtained from your DDP Coordinator.