

DEVELOPMENTAL DISABILITIES PROFILE REGISTRATION/MOVEMENT FORM

Fill in the blanks or mark the appropriate number for each shaded item. 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 checked="" type="checkbox"/> 2. Add	<input type="checkbox"/> 4. Remove	<input type="checkbox"/> 6. Transferred within Agency						
2	TABS ID: (if known)									
3	PERSON'S NAME:	LAST	FIRST	M.I.						
4	SEX:	<input type="checkbox"/> 1. Male	<input type="checkbox"/> 2. Female	5						
		DATE OF BIRTH								
		MO.	DAY	YR.						
6	COUNTY OF RESIDENCE	O N O N D A G A								
7	AGENCY NAME	Transitional Living Services		PROGRAM NAME						
		Family Community Inclusion								
8	REMOVE PROGRAM CODE									
		9	ADD PROGRAM CODE	6 5 0 9 0 8 2 1						
10	REMOVE/ADD DATE	MO.	DAY	YR.						
11	RESIDENTIAL ADDRESS (please print)	c/o								
		NAME								
		STREET								
		CITY STATE ZIP								
12	INDIVIDUALS RESIDENCE TYPE (mark only one)	<input type="checkbox"/> 1. Alone <input type="checkbox"/> 2. With Friends/House mates <input checked="" type="checkbox"/> 3. With member of His/Her own Family <input type="checkbox"/> 4. Department of Social Services Residence of Foster Care Home <input type="checkbox"/> 5. Nursing Facility <input type="checkbox"/> 6. Homeless or Shelter <input type="checkbox"/> 7. OMRDD/ Agency Operated Residence <input type="checkbox"/> 8. Other (specify)								
13	SOCIAL SECURITY NUMBER									
		14	PERSON'S MEDICAID Number (CIN)	_____ _____ _____ _____ _____ _____						
15	ETHNICITY/RACE:	<input type="checkbox"/> 1 White <input type="checkbox"/> 2 Black <input type="checkbox"/> 3 Hispanic <input type="checkbox"/> 4 Asian or Pacific Islander <input type="checkbox"/> 5 American Indian/Alaskan <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)	<table style="width: 100%; border: none;"> <tr> <td style="width: 33%;"> <input type="checkbox"/> 1 Developmental Delay <input type="checkbox"/> 2 Mental Retardation <input type="checkbox"/> 3 Autism <input type="checkbox"/> 4 Cerebral Palsy <input type="checkbox"/> 5 Epilepsy/Seizure disorder <input type="checkbox"/> 6 Learning Disability <input type="checkbox"/> 7 Other Neurological Impairment </td> <td style="width: 33%;"> <input type="checkbox"/> 8 Psychiatric Disability <input type="checkbox"/> 9 Chronic Physical/Medical Condition <input type="checkbox"/> 10 Sensory Impairment <input type="checkbox"/> 11 Undetermined <input type="checkbox"/> 12 Other (specify) <input type="checkbox"/> 13 Traumatic Brain Injury (TBI) <input type="checkbox"/> 14 Praeder-Willi Syndrome (PWS) </td> <td style="width: 33%;"> <input type="checkbox"/> 15 Fetal Alcohol Syndrome <input type="checkbox"/> 16 Narcolepsy <input type="checkbox"/> 17 Neurofibromatosis <input type="checkbox"/> 18 (Code Not Valid at this Time) <input type="checkbox"/> 19 Spina Bifida <input type="checkbox"/> 20 Tourette Syndrome <input type="checkbox"/> 21 Toxic Substance Exposure <input type="checkbox"/> 22 Child under 5 Unable to Diagnose </td> </tr> </table>			<input type="checkbox"/> 1 Developmental Delay <input type="checkbox"/> 2 Mental Retardation <input type="checkbox"/> 3 Autism <input type="checkbox"/> 4 Cerebral Palsy <input type="checkbox"/> 5 Epilepsy/Seizure disorder <input type="checkbox"/> 6 Learning Disability <input type="checkbox"/> 7 Other Neurological Impairment	<input type="checkbox"/> 8 Psychiatric Disability <input type="checkbox"/> 9 Chronic Physical/Medical Condition <input type="checkbox"/> 10 Sensory Impairment <input type="checkbox"/> 11 Undetermined <input type="checkbox"/> 12 Other (specify) <input type="checkbox"/> 13 Traumatic Brain Injury (TBI) <input type="checkbox"/> 14 Praeder-Willi Syndrome (PWS)	<input type="checkbox"/> 15 Fetal Alcohol Syndrome <input type="checkbox"/> 16 Narcolepsy <input type="checkbox"/> 17 Neurofibromatosis <input type="checkbox"/> 18 (Code Not Valid at this Time) <input type="checkbox"/> 19 Spina Bifida <input type="checkbox"/> 20 Tourette Syndrome <input type="checkbox"/> 21 Toxic Substance Exposure <input type="checkbox"/> 22 Child under 5 Unable to Diagnose			
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18	DATE COMPLETED	MO.	DAY	YR.						
19	COMPLETED BY (Print staff name)	PHONE NO.								