NEW YORK STATE OF OPPORTUNITY.

Office for People With Developmental Disabilities

DEVELOPMENTAL DISABILITIES PROFILE

A. IDENTIFCATION

1. Date Completed 05 / 17 / 2025

2. TABS ID

3. Agency / Program Name:

4. Agency / Program Code:

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

JAHANGIR, REDWAN

6. Birthdate 03 / 18 / 2004

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 the 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 Intellectual disability
☒ 3 Autism Spectrum Disorder
☐ 4 Cerebral palsy
☐ 5 Epilepsy / Seizure disorder
☐ 6 learning disorder (e.g., dyslexia, dysgraphia)
☐ 7 Other neurological impairment(s)
(e.g., Tourette's Syndrome, Prader-Willi)
☐ 8 Undetermined Developmental disability

11. From the developmental disability 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 Intellectual Disability
☒ 3 Moderate Intellectual Disability
☐ 4 Severe Intellectual Disability
☐ 5 Profound Intellectual Disability
☐ 6 Not determined at this time

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

☒ 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 Disease (MS, ALS, Huntington's Disease)	1	2

15. a. Does individual have history of seizures?

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

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

☒ 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
- ☐ 3 Antianxiety agent for behavior management
- ☐ 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

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 (cannot 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

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 Cannot 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

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 communication 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 details	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 verbal 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/pica	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. Behavioral challenges 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 behavioral challenges	1	2
d. Because of behavioral challenges, staff must sometimes intervene physically with individual (e.g., physically restrain individual or guide individual from room)	1	2
e. Because of behavioral challenges, a supervised "time-out" period is needed at least once a week	1	2
f. Because of behavioral challenges, individual requires one-on-one supervision for many program activities	1	2

G. SELF-CARE/DAILY LIVING SKILL

27. As best you can, indicate how **independently** individual **typically** preforms each activity:	TOTAL SUPPORT *Completely Dependent*	ASSISTANCE *Requires **lots** of hands-on help*	SUPERVISON *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 for 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*	SUPERVISON *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: Towhid Shiblee MD

TELEPHONE NO. (718) 247 7340