

**DIRECTIONS FOR COMPLETING THE
ODMR/DD LICENSED RESIDENTIAL FACILITY
VACANCY REGISTRY DATA COLLECTION FORM**

This form is to be completed to ensure the ongoing accuracy of the ODMR/DD Licensed Residential Facility Vacancy Registry. Please complete this form whenever a vacancy becomes available and mail or fax the information ODMR/DD.

***PLEASE PRINT OR TYPE ALL INFORMATION* (Possible electronic transmittal of form)**

ITEMS 1 THROUGH 11 ARE DEMOGRAPHIC DATA

- 1. List facility name on ODMR/DD license**
- 2. List facility number on ODMR/DD license(s)**
- 3. List full mailing address for facility**
- 4. List business phone number of facility**
- 5. List county in which the facility is located**
- 6. List by title or position the person to contact concerning the vacancy**
- 7. Identify facility type (ICR/MR, RFW, IO, other)**
- 8. List facility capacity on license**
- 9. List the number of vacancies in the facility**
- 10. Identify the date the vacancy(ies) became (will become) available**

ITEM 11 IS A RESIDENT'S PROFILE

- 11. Check all characteristics of residents who can be accommodated in the facility**

ITEM 12 IS THE FACILITY'S PROFILE

- 12. Check all available facility services**

GENERAL COMMENT(S) is to be completed with a brief summary of any additional information that the facility would like to share including, but not limited to, the facility's mission statement.

PLEASE RETURN THIS FORM TO:

**ODMR/DD, COMMUNITY SERVICES
LICENSED RESIDENTIAL FACILITY VACANCY REGISTRY
1810 SULLIVANT AVE. COLUMBUS, OHIO 43222**

OR FAX TO (614) 644-6676

**ODMR/DD LICENSED RESIDENTIAL FACILITY VACANCY REGISTRY
DATA COLLECTION FORM**

**(Refer to directions before completing)
Please Duplicate Form**

1. _____ 2. _____
Facility Name Facility Number
3. _____
Address City State Zip
4. (____) _____ 5. _____ 6. _____
Telephone number County Contact Person
7. Facility Type: ICF/MR ____ RFW ____ IO ____ Other (describe) _____
8. _____ 9. _____
Licensed Capacity Number of Vacancies
10. _____
Date Vacancy Available

11. RESIDENT'S PROFILE:

- | | |
|---|---|
| <input type="checkbox"/> male | <input type="checkbox"/> autism |
| <input type="checkbox"/> female | <input type="checkbox"/> MRO (mentally retarded offender) |
| <input type="checkbox"/> 0-3 years old | <input type="checkbox"/> dual diagnosis |
| <input type="checkbox"/> 4-22 years old | <input type="checkbox"/> Prader-Willie syndrome |
| <input type="checkbox"/> 23 to 60 years old | <input type="checkbox"/> hearing impaired |
| <input type="checkbox"/> 61 years old and up | <input type="checkbox"/> visually impaired |
| <input type="checkbox"/> medically fragile | <input type="checkbox"/> moderate retardation |
| <input type="checkbox"/> TBI (traumatic brain injury) | <input type="checkbox"/> severe retardation |
| <input type="checkbox"/> CP (cerebral palsy) | <input type="checkbox"/> profound retardation |
| <input type="checkbox"/> ambulatory | <input type="checkbox"/> behaviorally challenged |
| <input type="checkbox"/> non-ambulatory | <input type="checkbox"/> other (describe) _____ |

12. FACILITY PROFILE:

Staffing:

- nursing services
 nutritional services
 social service staff
 ancillary staff: OT; PT; Speech; Psychology
 other (describe): _____

Physical Facility:

Maximum number of persons sharing bedroom: _____

- single floor dwelling
- multiple floor dwelling
- wheelchair accessible

General Comments: _____

Completed By:

Name: _____ Title: _____ Date: _____

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