NORTH MISSISSIPPI REGIONAL CENTER

967 Regional Center Drive
Oxford, Mississippi 38655
www.nmrc.ms.gov
Diagnostic Services Department
Telephone: (662) 513-7728 Fax: (662) 513-7750
Email: apply@nmrc.ms.gov

The **North Mississippi Regional Center** provides a wide array of services to residents within the northern 32 counties of Mississippi who have intellectual or developmental disabilities. NMRC's various programs provide a continuum of services to these individuals, depending upon their specific needs and requests. Completed applications for services are accepted by fax, email, mail, or in person.

Diagnostic Services is the starting point for securing services through NMRC. This department provides multidisciplinary evaluations at no cost to determine eligibility for NMRC's programs and to assist in making referrals to other treatment programs. The professional staff can complete psychological, social, audiologic, medical, and nutritional assessments. Afterwards, applicants and family members meet with staff to discuss test findings and service options, such as those described below.

Social Services is the main link between NMRC and those persons seeking placement. NMRC is an intermediate care facility for persons with intellectual and developmental disabilities (ICF/IID) and as such, provides around-the-clock care and supervision as well as educational, vocational, and psychological and behavioral support services. Social Services coordinates all admissions to the ICF/IID programs on the main campus in Oxford and at the ICF/IID community homes throughout NMRC's catchment area.

Home and Community-Based Services are provided to persons with intellectual or developmental disabilities who are eligible for Medicaid and would require placement in an ICF/IID such as NMRC if support services were not available. HCBS may provide support coordination, transition assistance, nursing services, home and community support services, in-home respite services, community respite, adult day services, residential services (supervised and supported), prevocational services, job discovery, supported employment, specialized medical supplies, physical therapy, occupational therapy, behavior supports, crisis services, and speech therapy.

Community Support Program/1915i provides day services, prevocational services, supported employment, supported living, and in-home respite services to adults with intellectual and developmental disabilities who are over the age of 18, out of school, and receive full Medicaid benefits but are not immediately able to receive Home and Community-Based Services.

Applicants should retain this page for future reference.

It is the policy of the Department of Mental Health and each program to recruit, employ, and promote qualified employees and applicants, and to provide services to its clients, without regard to race, religion, color, sex, age, national origin, or disability. The Department of Mental Health/Bureau of Intellectual and Developmental Disabilities complies with the Americans with Disabilities Act of 1990. It is the purpose of this act to provide a clear mandate for the elimination against individuals with disabilities.

APPLICATION FOR SERVICES
MISSISSIPPI BUREAU OF INTELLECTUAL/DEVELOPMENTAL DISABILITIES PROGRAMS

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A. Applicant's Identifying Information

Full name: _____ Preferred name: _____

Date of Birth: _____ Sex: _____ Hair Color: _____

Age: _____ Height: _____ Religion: _____

Birthplace: _____ Weight: _____ Language: _____

Social Security #: _____ Eye Color: _____ Race: _____

Can applicant walk unassisted? ☐ Yes ☐ No Can applicant speak clearly? ☐ Yes ☐ No

Can applicant hear well? ☐ Yes ☐ No Can applicant see well? ☐ Yes ☐ No

Please explain any of the above marked "no": _____

_____

Applicant's Marital Status: _____ Date of Marriage: _____ Date of Divorce: _____

B. Contact Information

Current home street address: _____

City: _____ State: _____ Zip Code: _____

County: _____ Applicant's length of residence in Mississippi: _____

Mailing Address (if different from above) _____

Phone (day): _____ (night): _____ Email: _____

Current location if other than home (hospital, relative's home, emergency shelter, etc.) _____

For how long and why? _____

Person completing application: _____

Relationship to applicant (e.g., parent, sibling, legal representative): _____

C. Reason for Requesting Services

Who referred the applicant to NMRC? _____

Relationship/Agency: _____

Referral Source's Telephone: _____ Fax: _____ Email: _____

Why is application being made at this time? _____

_____

_____

D. History of Intellectual/Developmental Disabilities or Delays

Give name, address, and title of person family first consulted about the problem: _____

_____

When? _____ Results of consultation: _____

_____ (attach reports, if available.)

Has the applicant ever had a psychological evaluation? ☐ Yes ☐ No If yes, give name and address of examiner: _____

What were the findings of that examination? _____

Has the applicant ever been admitted to a mental or psychiatric hospital or program for persons with intellectual/developmental disabilities? ☐ Yes ☐ No If yes, give name(s) of institution(s) and date(s) of residency: _____

_____

List below **contacts** with social agencies, hospitals, clinics, physicians, psychologists, psychiatrists, speech pathologists, audiologists, etc. (attach separate page if necessary)

Name/Agency	Street Address	City/State	Date Seen

E. Gestation, Birth, and Neonatal History

Mother's general health during pregnancy: _____

Were there any accidents, injuries, illnesses, infections, or unusual symptoms during pregnancy? ☐ Yes ☐ No

If yes, explain: _____

_____

_____

Was the mother under a physician's care during pregnancy? ☐ Yes ☐ No How long? _____

List medications taken by mother during pregnancy: _____

_____

Was the applicant exposed to alcohol, drugs, or tobacco during pregnancy? ☐ Yes ☐ No

Was the applicant a full-term baby? ☐ Yes ☐ No If no, at how many months/weeks did birth occur? _____

Did the mother have any problems during **labor?** ☐ Yes ☐ No Problems during **delivery?** ☐ Yes ☐ No

If yes, please explain: _____

_____

Was birth by Caesarean section? ☐ Yes ☐ No If yes, explain: _____

Were there any problems noted at birth? ☐ Yes ☐ No If yes, explain: _____

_____

Birth weight: _____ Birth length: _____

Did the birth occur at a hospital? ☐ Yes ☐ No Hospital name:_____

Labor: ☐ Spontaneous ☐ Induced

If induced, why? _____

F. Early Development

At what age were applicant's difficulties or developmental delays noted? _____

Please describe the changes that were noticed: _____

_____

At **what age** was the applicant able to do the following:

Turn head toward voice		Babble	
Hold head up		Say "mama" or "dada" with meaning	
Follow object w/ eyes		Sit alone	
Coo and laugh		Pull self up	
Roll over		Stand alone	

Does applicant **walk?** ☐ Yes ☐ No At what age did s/he begin walking alone? _____

Was there any difficulty learning to walk? ☐ Yes ☐ No If yes, explain: _____

Does s/he use **crutches or a walker?** ☐ Yes ☐ No **Wheelchair?** ☐ Yes ☐ No Other **aides**: _____

Does applicant **talk?** ☐ Yes ☐ No At what age did s/he begin? _____ Please describe any problems with speech or communication: _____

_____

In which of the following ways does the applicant **communicate?** Select all that apply.

☐ Words _____ ☐ Sign language _____

☐ Gestures _____ ☐ Communication Device _____

☐ Sounds _____ ☐ Other _____

Is applicant **toilet-trained?** ☐ Yes ☐ No ☐ Partially Explain: _____

At what age did toilet training begin? _____ At what age was it completed? _____

G. Medical History and Information

Has the applicant had any **genetic testing?** ☐ Yes ☐ No

If yes, when and where? _____

Findings? _____

Current medical diagnoses: _____

_____

Current Medications (list on separate page if needed):

Medication Name	Dosage	Prescribing MD	Reason for Medication	When first prescribed

Has the applicant ever had any of the following **diagnoses?** If yes, at **what age?**

Tuberculosis	☐ Yes ☐ No _____	Meningitis	☐ Yes ☐ No _____
Whooping cough	☐ Yes ☐ No _____	Mumps	☐ Yes ☐ No _____
Chicken Pox	☐ Yes ☐ No _____	Hepatitis	☐ Yes ☐ No _____
Scarlet Fever	☐ Yes ☐ No _____	Measles	☐ Yes ☐ No _____
HIV/AIDS	☐ Yes ☐ No _____		

Did applicant's condition (physical or mental) change noticeably after having one of the above illnesses?

☐ Yes ☐ No If yes, indicate which and explain: _____

_____

Are **vaccinations** up to date? ☐ Yes ☐ No

Does applicant have **allergies** to food, medication, or another substance? ☐ Yes ☐ No

If yes, what items cause allergic reactions? _____

Describe the reaction: _____

Has the applicant ever been **hospitalized?** ☐ Yes ☐ No If yes, please indicate why, at what age, and the name and city/state of the hospital: _____

_____

Has the applicant ever had serious **illnesses, accidents, injuries, or surgeries?** ☐ Yes ☐ No

If yes, please explain: _____

_____

Has applicant ever had a **high fever?** ☐ Yes ☐ No If yes, how high? _____

How long did it last? _____ Cause of fever? _____

Has the applicant ever had a **convulsion/seizure?** ☐ Yes ☐ No If yes, at what age? _____

Have seizures/convulsions continued? ☐ Yes ☐ No How frequent? _____

Please list any changes after seizures/convulsions began: _____

_____

List **current** medications for seizures/convulsions: _____

List **previous** medications for seizures/convulsions: _____

Does the applicant use **tobacco?** ☐ Yes ☐ No **Alcohol?** ☐ Yes ☐ No **Drugs?** ☐ Yes ☐ No

Amount and frequency of use? _____

H. Abilities and Behaviors

Able to dress and undress self? ☐ Yes ☐ No ☐ Partially _____

Able to bathe self? ☐ Yes ☐ No ☐ Partially _____

Able to groom self (brushing teeth, combing hair, etc.)? ☐ Yes ☐ No ☐ Partially _____

Able to feed self? ☐ Yes ☐ No ☐ Partially _____

Able to drink from a glass? ☐ Yes ☐ No ☐ Partially _____

Able to use spoon? ☐ Yes ☐ No ☐ Partially _____

Able to use fork? ☐ Yes ☐ No ☐ Partially _____

Able to use knife? ☐ Yes ☐ No ☐ Partially _____

Does the applicant eat primarily with his/her hands? ☐ Yes ☐ No ☐ Sometimes

Does the applicant do simple chores or errands at home? ☐ Yes ☐ No

Examples of chores? _____

Does the applicant sleep well and quietly? ☐ Yes ☐ No

If no, explain: _____

Does the applicant have any **problematic behaviors** that are of concern? ☐ Yes ☐ No

If yes, please describe them: _____

_____

Describe the **level of supervision** required at home, in school, in public: _____

_____

List any medications taken for behavior problems: _____

I. Education History and Achievement

Has applicant attended school? ☐ Yes ☐ No If so, list school, dates attended, and highest grade reached:

School Name, City, and State	Dates attended (From/To)		Highest Grade Reached

Has the applicant ever had a **special education ruling** or attended **special education classes**? ☐ Yes ☐ No

If yes, what is/was the ruling (e.g., intellectual disability, autism, ADHD, speech/language, other health impairment, etc.)? _____

If the applicant was in school at one time and then removed, why was s/he removed? _____

_____

When did applicant graduate regular high school? _____ Receive an occupational diploma? _____

Receive a certificate of attendance? _____ Discontinue without a diploma? _____

Can s/he read? ☐ Yes ☐ No To what extent? _____

Can s/he write? ☐ Yes ☐ No How well? _____

Can s/he count? ☐ Yes ☐ No How high? _____

Describe the applicant's ability to handle money, make change, pay bills, etc.? _____

_____

Has the applicant been previously employed? ☐ Yes ☐ No

Employer/Program	Dates	City, State	Primary job tasks

J. Applicant's Biological Family

Are the applicant's parents blood relatives? ☐ Yes ☐ No If so, how? _____

Date of Marriage: _____ Separation: _____ Divorce: _____

Applicant's Biological Father

Name: _____ Birthdate: _____

Address: _____ Birthplace: _____

Phone (day): _____ (night): _____ Email: _____

Age at birth of applicant: _____ Highest level of school completed: _____

Occupation: _____ Employer: _____

Employer phone number, city, and state: _____

Father's health: ☐ Good ☐ Fair ☐ Poor If fair or poor, please explain: _____

_____

_____

Is there a **history of the following diagnoses** in the father or his immediate family (if yes, who/what?):

☐ Yes ☐ No Intellectual/Developmental disorders: _____

☐ Yes ☐ No Mental health disorders: _____

☐ Yes ☐ No Seizures/Convulsions: _____

☐ Yes ☐ No Birth defects or Problems: _____

Other marriages? Give name(s)/date(s): _____

If applicant's father is deceased, give date: _____ Cause of death: _____

Applicant's paternal grandfather: _____ Paternal grandmother: _____

Applicant's Biological Mother

Name: _____ Maiden: _____ Birthdate: _____

Address: _____ Birthplace: _____

Phone (day): _____ (night): _____ Email: _____

Age at birth of applicant: _____ Highest level of school completed: _____

Occupation: _____ Employer: _____

Employer phone number, city, and state: _____

Mother's health: ☐ Good ☐ Fair ☐ Poor If fair or poor, please explain: _____

_____

_____

Is there a **history of the following diagnoses** in the mother or her immediate family (if yes, who/what?):

☐ Yes ☐ No Intellectual/Developmental disorders: _____

☐ Yes ☐ No Mental health disorders: _____

☐ Yes ☐ No Seizures/Convulsions: _____

☐ Yes ☐ No Birth defects or Problems: _____

Other marriages? Give name(s)/date(s): _____

If applicant's mother is deceased, give date: _____ Cause of death: _____

Applicant's maternal grandfather: _____ Maternal grandmother: _____

Applicant's Siblings

Name	Date of Birth	Age	Sex	City/State (if not at home)	Physical health (good, fair, poor, deceased)	Mental health (good, fair, poor, deceased)

Please explain any unusual mental or physical conditions noted in siblings. Attach pages if necessary. _____

_____

_____

_____

Applicant's Household: Please list others who are living in the home.

Name	Date of Birth	Age	Sex	Relationship to Applicant	Physical health (good, fair, poor)	Mental health (good, fair, poor)

K. Financial Information

Does the applicant **receive benefits** from any of the following:

Social Security: ☐ Yes ☐ No Amount: _____ Payee: _____

SSI: ☐ Yes ☐ No Amount: _____ Payee: _____

Veteran's Administration: ☐ Yes ☐ No Amount: _____ Payee: _____

Child Support: ☐ Yes ☐ No Amount: _____ Payee: _____

Other: ☐ Yes ☐ No Amount: _____ Payee: _____

Does the applicant have hospitalization insurance: ☐ Yes ☐ No Name of insured: _____

Name of company: _____

Name as shown on **Medicaid card**: _____ Number: _____

Name as shown on **Medicare card**: _____ Number: _____

List any other service providers for the applicant: _____

Does the applicant have **burial insurance**? ☐ Yes ☐ No Name of company and address: _____

_____

L. Adoption Status

Was the applicant adopted? ☐ Yes ☐ No If yes, date adoption granted: _____

Name and Agency from which adopted: _____

Applicant's birth name (if known): _____

Applicant's biological parents' names (if known): _____

M. Guardianship Status

Has a **legal guardian/conservator** been appointed by the court? (*Please note: Applicants over 21 are responsible for themselves unless a legal guardian has been appointed by the court*.) ☐ Yes ☐ No ☐ Under 21

If yes, date appointed: _____

Name of guardian: _____

Current home address: _____

City: _____ State: _____ Zip Code:_____

Mailing Address (if different from above) _____

Phone (day): _____ (night): _____ Email: _____

Occupation: _____ Employer: _____

If legal guardianship/conservatorship has been appointed, court documents must be returned with this application for services.

I certify that the above questions regarding this applicant have been answered accurately to the best of my knowledge.

_____ _____
Signature of person completing this application (indicate relationship) Date

_____ _____
Signature of applicant (if over 21 years of age and without a legal guardian) Date

_____ _____
Signature of parent of applicant Date

_____ _____
Signature of parent of applicant Date

_____ _____
Signature of legal guardian/other responsible party Date