NORTH MISSISSIPPI REGIONAL CENTER

967 Regional Center Drive
Oxford, Mississippi 38655
Telephone: (662) 234-1476 Fax: (662) 234-1699
www.nmrc.ms.gov
Diagnostic Services Department
Telephone: (662) 513-7728 or (662) 513-7941
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 services, and supported living services to adults with intellectual and developmental disabilities over the age of 18 who receive 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 a physician attend the birth of the applicant? ☐ Yes ☐ No 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 18 are responsible for themselves unless a legal guardian has been appointed by the court*.) ☐ Yes ☐ No ☐ Under 18

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 18 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