



## NORTH MISSISSIPPI REGIONAL CENTER

967 Regional Center Drive

Oxford, Mississippi 38655

[www.nmrc.ms.gov](http://www.nmrc.ms.gov)

### Diagnostic Services Department

Telephone: (662) 513-7728 Fax: (662) 513-7750

Email: [apply@nmrc.ms.gov](mailto: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. \_\_\_\_\_

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**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: \_\_\_\_\_

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**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