



North Mississippi Regional Center Application for Services

The North Mississippi Regional Center provides a wide array of services to residents within the northern 23 counties of Mississippi with mental retardation and other developmental disabilities. The Center's various programs provide a continuum of services to these individuals, depending upon their specific needs and requests. To access these programs, please complete the attached application and return it to Diagnostic Services, North Mississippi Regional Center, 967 Regional Center Drive, Oxford, MS 38655.

Diagnostic Services is the starting point for securing services through NMRC. This department provides free, multidisciplinary evaluations to determine eligibility for most of NMRC's programs and to assist in making referrals to other treatment programs. The professional staff can complete intellectual, audiologic, educational, medical, and nutritional assessments. Afterwards, applicants and family members meet with staff to discuss test findings and options for treatment. Families may then request further services, such as those described below.

Social Services is the main link between the Center and those persons seeking to live at the facility. NMRC is an intermediate care facility for persons with mental retardation (ICF/MR) and as such, provides around-the-clock care and supervision as well as educational, vocational, and psychological support services. Social Services coordinates all admissions to the ICF/MR programs on the main campus in Oxford and at the 10-bed community homes throughout NMRC's catchment area.

Project RUN, which stands for Reaching Us Now, is an early intervention program for children with developmental disabilities from birth to three years of age. Individualized services in the areas of education, physical therapy, occupational therapy, and communication are provided as well as educational and support services for the families. These services are provided on the main Oxford campus of NMRC, at satellite programs in Grenada, Hernando, and Clarksdale, and through outreach services in surrounding counties.

Home and Community-Based Services are provided to persons with mental retardation/developmental disabilities who are eligible for Medicaid and would require placement in an ICF/MR such as NMRC if support services were not available. HCBS may provide attendant care services, in-home respite services, adult day habilitation, residential habilitation, prevocational services, supported employment, specialized medical supplies, physical therapy, occupational therapy, behavior intervention, and speech/language/hearing therapy.

Case Management provides further information, referral, and follow-up assistance to all eligible applicants.

Community Support Systems operates community-based programs including group homes, supervised apartments, work activity centers, and supported employment.

It is the policy of the Department of Mental Health and each facility 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 Mental Retardation complies with the Americans with Disabilities ACT (ADA) of 1990. It is the purpose of this act to provide a clear mandate for the elimination of discrimination against individuals with disabilities.

Applicants should retain this page for future reference

APPLICATION FOR SERVICES
MISSISSIPPI BUREAU OF MENTAL RETARDATION/DEVELOPMENTAL DISABILITIES PROGRAMS

North Mississippi Regional Center
967 Regional Center Drive
Oxford, Mississippi 38655
Telephone: (662) 234-1476
Fax: (662) 234-1699
www.nmrc.state.ms.us



For Office Use Only

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Identifying Information

Applicant's name in full _____ Birthdate _____

Nickname _____ Birthplace _____ Social Security Number _____

Current home address _____ County _____

City _____ State _____ Zip _____ Telephone (day) _____ (night) _____

Mailing address (if different from above) _____

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

For how long and why _____

Applicant's length of residence in Mississippi _____ Religion _____

Important current medical diagnoses _____

Sex _____ Height _____ Weight _____ Eye Color _____ Hair Color _____ Race _____ Age _____

Can applicant walk unassisted? _____ If not, describe _____

Can applicant speak clearly? _____ If not, describe _____

Can applicant hear well? _____ If not, describe _____

Can applicant see well? _____ If not, describe _____

Applicant's marital status _____ Date of marriage _____ Date of divorce _____

Applicant's spouse's name and address _____

Names, ages, and addresses of applicant's children _____

Applicant's current employer, address, and telephone number _____

Name, address and relationship of preferred correspondent _____

Telephone (day) _____ (night) _____ e-mail _____

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List below current medications being taken (list others on separate page if necessary)

Medication Name	Dosage	Prescribing MD	Reason for medication	When first prescribed

Gestation, Birth, and Neonatal History

Were there any illnesses, infections, or unusual symptoms during pregnancy? Yes _____ No _____
 If yes, please explain _____

Was mother under a physician's care during pregnancy? _____

How long during pregnancy was she under a physician's care? _____

List medication mother took during pregnancy _____

Was mother x-rayed during pregnancy? _____ When and why _____

Did mother have any accidents or injuries during pregnancy? _____ If so, give details _____

Mother's general health during pregnancy _____

Was applicant a full-term baby? _____ If no, in what month of pregnancy did birth occur? _____

Was labor spontaneous? _____ Induced? _____ If induced, why? _____

How long did labor last? _____

Did mother have problems with any of the following during labor?

Excessive bleeding _____ Fever _____ Convulsions/Seizures _____

Loss of consciousness _____ Labor stopped by itself _____

Attempts made to stop labor _____ If yes, give details _____

Was there anything unusual about delivery? _____ If yes, explain _____

Were instruments used in delivery? _____ If so, type _____ Forceps _____

Was birth by Caesarean section? _____ If yes, explain _____

Was cord prolapsed? _____ About the neck? _____ Was placenta abnormal? _____

Was there any difficulty in getting applicant to breathe immediately after delivery? _____

If yes, explain _____

Was there anything unusual in the appearance of applicant immediately after birth? _____ If yes, explain _____

Birth weight _____ Length _____ Head circumference _____

Did a physician attend the birth of applicant? _____ If yes, give name and address _____

Was applicant born in a hospital? _____ At home? _____ If hospital, give name and address _____

Describe any physical problems noted at birth _____

Please describe any other health problems immediately following birth _____

Did newborn hospital tests reveal any problems such as

Phenylketonuria (PKU)		Sickle Cell	
Galactosemia		Hearing loss	
Hypothyroidism		Other	

Early Development

Was applicant breast fed? _____ Bottle fed? _____

At what age was s/he weaned? _____ Was there any unusual difficulty? _____

Describe any feeding or nursing difficulties _____

At what age were applicant's difficulties or mental retardation noted? _____ Please describe the changes that were first noted _____

At what age was the applicant able to do the following things

Turn head toward voice		Say "Mama" or "Dada" with meaning	
Follow objects with eyes		Sit alone	
Coo and laugh		Wave "Bye-Bye"	
Hold head up		Pull up	
Turn over		Stand alone	
Babble		Feed self	
Reach for objects		Throw ball	

Is applicant bedfast? _____ Does applicant walk? _____ At what age did s/he begin walking alone? _____

Was there any difficulty learning to walk? _____ If so, please explain _____

Does he/she use crutches? _____ Wheelchair? _____ Other aids or assistance? _____

Does applicant talk? _____ At what age did he/she begin? _____ Please describe any problems with speech or communication _____

At what age was toilet training begun? _____ Is applicant bowel trained? Yes _____ No _____

Partially _____ If yes, what was age completed? _____

Does applicant have any physical abnormality or disorder? _____ If yes, please explain _____

Has applicant undergone genetic testing? _____ When? _____

If so, what were the findings _____

Medical History Information

Has applicant ever had any of the following? (Give age)

Measles, Red		Meningitis		Pneumonia	
Whooping Cough		Rheumatic Fever		Mumps	
German Measles		Bronchitis		Diphtheria	
Encephalitis		Severe Diarrhea		Jaundice	
Chicken Pox		Poliomyelitis		Hepatitis	
Scarlet Fever		Tuberculosis		HIV/AIDS	

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

If yes, please indicate which and explain _____

Does applicant have allergies? _____ If yes, type of food, medicine or other substance causing allergy _____

Describe the allergic reaction _____

Has applicant ever been hospitalized? _____ If yes, please indicate why, at what age, the name and address of the hospital and attending physician _____

Has applicant ever had a serious accident or injury? _____ If yes, please explain _____

Has applicant ever had a high fever? _____ If yes, how high? _____ How long did it last? _____

What caused it? _____

Has applicant ever had a convulsion/seizure? _____ If yes, give age at which this occurred _____

Has applicant continued to have convulsions/seizures? _____ If so, how frequent? _____

Please discuss any change in behavior after onset _____

List current medications taken for convulsions/seizures _____

List previous medications taken for convulsions/seizures _____

Abilities and Behavior

Is applicant able to dress and undress himself? Yes _____ No _____ Partially _____

Can applicant attend to personal grooming, such as bathing, combing hair, brushing teeth, etc.?

Yes _____ No _____ Partially _____

Can applicant feed him/herself? Yes _____ No _____ If yes, does s/he use hands _____

Spoon _____ Fork _____ Knife _____ Can applicant drink from a glass? _____

Does applicant obey? _____ Is applicant a problem in management? _____ If yes, please explain _____

Is applicant destructive? _____

Does s/he have temper tantrums? _____

Is applicant able to do errands and carry out simple chores around the house? _____ If yes, please explain _____

Does applicant sleep well and quietly? _____ If no, please explain _____

Describe the level of supervision the applicant requires at home, in school, and in public _____

List any medications previously taken for behavior _____

Educational History and Achievement

Has applicant attended school? _____ If so, list school, dates attended and highest grade reached

School/Address	Date Attended		Highest Grade Reached
	From	To	

Has the applicant ever had a special education ruling or attended special education classes? _____

If so, please describe _____

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

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

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

Can applicant read? _____ If yes, to what extent is he able to read and understand? _____

Can applicant write? _____ If yes, how well? _____

Can applicant count? _____ If yes, how high? _____

Is applicant able to make change with money? _____

Applicant's Father

Name _____ Birthdate _____

Address _____ Birthplace _____

Telephone (home) _____ (cell) _____ (e-mail) _____

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

Occupation _____ Social Security number _____

Place of employment _____

Phone number and address _____

Military status _____ Branch _____ Service number _____ VA number _____

Health--Good _____ Fair _____ Poor _____ If fair or poor, please explain _____

Father's name (applicant's paternal grandfather) _____

Mother's name (applicant's paternal grandmother) _____

Is there a history of any of the following in the father or his immediate family?

Mental Retardation		Venereal Diseases	
Mental or Nervous Disorders		Epileptic Seizures or Convulsions	
Abortions or Stillborns		Birth Defects or Problems	

If any of these are checked, please explain by giving name of individual experiencing disorder, relationship to applicant, and short history of disorder, explaining how it affects or affected the individual having it _____

Are the applicants' parents related to each other? _____ If so, how? _____

Date of marriage _____ Separation _____ Divorce _____

Other marriages (give date) _____

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

Applicant's Mother

Name (include maiden name) _____ Birthdate _____

Address _____ Birthplace _____

Telephone number (home) _____ (cell) _____ (e-mail) _____

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

Occupation _____ Social Security number _____

Place of employment _____

Phone number and address _____

Military status _____ Branch _____ Service number _____ VA number _____

Health--Good _____ Fair _____ Poor _____ If fair or poor, please explain _____

Father's name (applicant's maternal grandfather) _____

Mother's name (applicant's maternal grandmother) _____

Is there a history of any of the following in the mother or her immediate family?

Mental Retardation		Venereal Diseases	
Mental or Nervous Disorders		Epileptic Seizures or Convulsions	
Abortions or Stillborns		Birth Defects or Problems	

If any of these are checked, please explain by giving name of individual experiencing disorder, relationship to applicant, and short history of disorder, explaining how it affects or affected the individual having it _____

Other marriages (give date) _____

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

Siblings

List all brothers and sisters from oldest to youngest, including those deceased and any miscarriages or stillborns.

Name	Date of birth	Age	Sex	Address (If not at home)	Health * (Good, fair, poor or deceased)	Mental health* (Good, fair, or poor)

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

Household

Please list other people living in the home

Name	Date of Birth	Age	Sex	Relationship

Adoption Status (If applicant is adopted, please answer the following.)

Age at which applicant began living in the adoptive home _____ Date adoption granted _____

Name and address of agency from which adopted _____

Applicant's birth name (if known) _____

Applicant's natural parents names (if known) _____

Legal Guardian (Complete if parents are deceased, separated or divorced, or if custody has been placed away from the parents. Applicants over 21 are responsible for themselves unless legal guardian has been appointed.)

Name _____

Address _____

Phone No. (day) _____ (night) _____ (E-mail) _____

Date of Birth _____ Social Security No. _____

Occupation _____ Employer _____

Active Military Service _____ Branch _____ Service No. _____

(Legal Guardian must provide copy of legal documents as proof of custody.)

Financial Information

Does applicant receive benefits from any of the following

Social Security _____ Amount _____ Payee _____

SSI _____ Amount _____ Payee _____

Veteran's Administration _____ Amount _____ Payee _____

Child Support Payments _____ Amount _____ Payee _____

Other _____ Amount _____ Payee _____

Does applicant have hospitalization insurance? _____ Name of insured individual _____

Give name and address of company _____

Policy No. _____

Name as shown on Medicaid card _____ Number _____

Name as shown on Medicare card _____ Number _____

Is applicant receiving Children's Medical Services? _____

Is applicant receiving services from any other person, professional, or agency? _____ If yes, list _____

Does applicant have burial insurance? _____ Name of company and address _____

Monthly income of parents/guardian _____

Monthly income of applicant _____

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

Person completing this application (please indicate relationship)

Date

Applicant (If over 18 years of age and without legal guardian)

Date

Parent of applicant

Date

Parent of applicant

Date

Legal guardian or other responsible party

Date