APPLICATION FOR SERVICES
MISSISSIPPI BUREAU OF INTELLECTUAL AND DEVELOPMENTAL DISABILITIES PROGRAM

North Mississippi
967 Regional Center Drive
Oxford, MS 39655

Ellisville State School
1101 Hwy 11 South
Ellisville, MS 39437

Hudspeth Regional Center
Post Office Box 127-B
Whitfield, MS 39193

South Ms. Regional Center
1170 West Railroad Street
Long Beach, MS 39560

Boswell Regional Center
Post Office Box 128
Magee, MS 39111-0128

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For Office Use Only

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I. APPLICANT

A. **Identifying Information**:

1. Name in full:____
   Nickname:____
2. Birthdate:_________________________________ Age: ______________________________
3. Street Address____________________________City:________________________________
   Mailing Address___________________________ City:________________________________
   State______________________ Zip Code: ______________County:_________________
   Telephone Number: (____)____________ Length of Residence in Mississippi:________
4. Gender:__________ Race:________ Birthplace:____________ Religion:____________
5. Marital Status: ________ Social Security Number: _______________________________

6. **Father's Name**: ____
   Telephone #: HOME:_______________________ WORK: ________________________
   Address:_______________________________City:________________Zip:___________

7. **Mother's Maiden Name**:____
   Telephone #: HOME:_______________________ WORK: ________________________
   Address: ______________________________ City: ________________Zip:__________

8. **Other Responsible Relative**: ____
   Telephone #: HOME: _______________________ WORK: ________________________
   Address:______________________________ City: _________________ Zip:__________
   Relationship to Applicant: ____
9. Has a legal guardian been appointed?______ YES ______ NO.
   If yes indicated name and relationship:
   Name:__________________________________Relationship:_______________________

II. SERVICE REQUESTED:
Please indicate service (s) you are requesting:

1

( ) Diagnostic Services
( ) Case Management
( ) Pre-School Intervention
( ) Community Living Options
( ) Vocational Options
( ) Family Support Services
( ) Home and Community Based
ID/DD Medicaid Waiver Services
( ) ICF/MR Community Home
( ) Residential (Center Based)
( ) Long Term (Active)
( ) Holding (Inactive)
( ) Short Term (Respite)
( ) Assistive Technology Evaluation
( ) Other (Client's own words:)____
____

2. Reason service (s) requested: ____
____
____

III. MEDICAL INFORMATION:

1. Describe applicant's disability (applicant's own description): ______________________
____
____
____

2. List below contacts with social agencies, clinics, physician, dentists, psychologists, psychiatrists, speech pathologists, audiologists, occupational or physical therapists:

Name/Agency	Mailing Address	City/State/Zip	Dates of Service

3. Has applicant ever had any of the following:
(Please check appropriate blank (s) and indicate age.)

Hepatitis ❑YES ❑ NO _________AGE
Yellow Jaundice ❑YES ❑ NO _________AGE
Tuberculosis ❑YES ❑ NO _________AGE

4. Does applicant have allergies? ❑YES ❑ NO
If yes, please list type of food, medicine, or other substances causing allergy:

5. Has applicant ever been hospitalized? ❑ YES ❑NO
If yes, please indicate why, at what age, the name and address of the hospital and the attending physician.

Name of Hospital	**Address**	**Reason for admission**	**Age**	**Physician's name**

6. Has applicant ever had a serious accident or injury? ❑YES ❑NO
If yes, please explain what happened:

Type of accident/injury	**Date of accident/injury**	**Describe changes in behavior/motor ability**

7. Does applicant have a visual impairment? ❑YES ❑ NO
If yes, does applicant wear glasses or other visual aid (s)? ❑ YES ❑ NO
If yes, please list type of aid (s): ____

8. Does applicant have a hearing impairment? ❑YES ❑NO
If yes, please list type of aid (s):____

9. Does applicant have any physical abnormalities? ❑YES (please explain) ❑ NO

Physical abnormalities	**Age abnormalities first noticed**

10. Has applicant ever had a seizure? ❑YES ❑NO
If yes, give age at which this occurred: _____________. Has applicant continued to have seizures? ___________. If yes, how frequent? ______________ How long does each seizure last? ________________. Does applicant sleep after a seizure? ________. Please list any changes in behavior after onset of seizures:
____
____
Is applicant presently taking medication for seizures? ❑YES ❑NO

Name of anticonvulsant Medicine	Dosage	Name of anticonvulsant meds taken in the past

11. Is applicant presently taking medication for behavior? ❑ YES ❑ NO

Name of Medication	Dosage	Frequency

12. Does applicant take any other medications? ❑YES ❑NO. If yes, please list:

Name of Medication	Dosage	Frequency

Please provide an attachment of medications if there is not appropriate space

IV. ABILITIES AND BEHAVIOR:

1. Is applicant able to walk? ❑ YES ❑NO
Does he/she use crutches? ❑ Wheelchair ❑
Specify other ambulation aid (s)____

2. Can applicant feed him/herself? ❑ YES ❑NO: If yes does he/she use:

❑ **hands** ❑ **spoon** ❑ **fork** ❑ **knife**

Can applicant drink from a glass? ❑YES ❑NO:

Does applicant have any feeding problems? ❑ YES ❑NO: If yes, please describe:

____

____

3. Does applicant talk? ______; Use sign language?______; Use gesture? ______; Use an augmentative communication system? _____; Language spoken and understood?______

4. Does applicant use any other kind of assistive device, i.e., computer, environment control unit, other?________ If yes, please specify: ___________________________________
____

5. Is applicant toilet trained? ❑ YES; ❑ NO; ❑ PARTIALLY

6. Is applicant able to dress and undress him/herself? ❑ YES ❑NO ❑ PARTIALLY

7. Can applicant attend to personal grooming, such as bathing, combing hair, brushing teeth, etc...? ❑YES ❑NO ❑PARTIALLY

8. Is applicant a problem in management? ❑YES ❑ NO. If yes, please describe behaviors: ____
____
____

9. Does applicant have any sleep difficulties? ❑YES (Please explain below) ❑ NO.
____
____

10. Is applicant able to perform errands and carry out simple chores around the house? ❑YES ❑ NO. If yes, give examples: ____
____

V. RESIDENTIAL INFORMATION:

1. Where is applicant presently residing ?

( ) Family Home
( ) Group Home
( ) Supervised Apartment
( ) Supported Living
( ) Independent Living
( ) Personal Care Home
( ) Nursing Home
( ) Foster Home
( ) ICF/MR Facility
( ) Other: _________________

2. If applicant is not residing at family home, please provide date of admission to residence

Name of Residential Facility	Date of Admission

3. Please provide name, address, relationship and telephone number of contact person, if not living at family home:

Contact Person	Address	Telephone #	Relationship

4. Has applicant previously been admitted to any type of residential program?___________
If yes, please provide the following information:

Name of Program/ School	Date Admitted	Date Discharged	Reason for leaving

VI. EDUCATIONAL/VOCATIONAL INFORMATION:

1. Is applicant involved in any activity outside of the home at this time? **(i.e. day care**, **school, job, work activity or supported employment, volunteer work)** ❑YES ❑NO

Type of activity	Initiation date

.

2. Please list any previous **school systems/vocational programs/employment opportunities** in which applicant has participated:

Name of Agency	Admission Date	Discharge Date	Reason for leaving

VII. FAMILY DATA:

A.

Father's Name	Date of Birth	Birthplace	Age at birth of applicant

2. Level of education: (Please circle one)
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20

3. Occupation:______________________________Social Security #: ___________________

4. Health: ❑Good ❑Fair ❑Poor. If fair or poor, please explain
____

5. Date of marriage:______________; Separation_______________; Divorce _____________
Other marriages: _____________________ ________________ __________________

6. If father of applicant is deceased, please give date and cause of death.
Date:__________________ Cause of death_____________________________________

B.

Mother's Name	Date of Birth	Birthplace	Age at birth of applicant

2. Level of education: (Please circle one)
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20

3. Occupation:______________________________Social Security #: ___________________

4. Health: ❑Good ❑Fair ❑Poor. If fair or poor, please explain
____

5. Date of marriage:______________; Separation_______________; Divorce _____________
Other marriages: _____________________ ________________ __________________

6. If mother of applicant is deceased, please give date and cause of death.
Date:__________________ Cause of death_____________________________________

C. Is there a history of the following in the father, mother or his/her immediate family:

DISEASE	FATHER	MOTHER
Mental Retardation	______	______
Mental or Nervous Disorder	______	______
Seizures	______	______
Cancer	______	______
Cardiovascular Disease (Heart, High Blood Pressure, Strokes)	______	_______

If any of these are checked, please explain in the area provided below:

Name of Individual	Relation to Applicant	History of Disorder

D. Are the applicant's parents related to each other? __________. If yes, how are they related? ____

E. **Siblings:** Please list applicant's siblings in order from oldest to youngest. Include those who are deceased. Also list any miscarriages or stillborns.

Name	Age	Gender	Address	Physical Condition	Mental Condition

Please provide an attachment of medications if there is not appropriate space

If siblings have any unusual physical conditions, please explain:
____
____
____

F. Please list other people living in the home:

Name	Age	Gender	Relationship

G. If applicant is adopted, please give age at which adopted ___________________________

VIII. FINANCIAL INFORMATION:

1. Does applicant receive benefits from any of the following:

( ) Social Security	Amount:____________	Payee____________________
( ) SSI	Amount: ____________	Payee____________________
( ) Veteran's Administration	Amount: ____________	Payee____________________
( ) Other	Amount: ____________	Payee____________________
( ) Wages, if employed	Amount: ____________	Payee____________________

2. Does applicant have private hospitalization insurance? ❑YES ❑NO
   If yes, give name and address of insurance company: ______________________________
   ____
   Policy number: ___________________________________
3. Please provide the following information:
   Medicaid Number: ____________________ Medicare Number:____________________
4. Does applicant have burial insurance? ❑YES ❑ NO. If yes, provide name of
   company and address: ____
   ____

IX. BIRTH AND DEVELOPMENTAL HISTORY:

1. Were there any illnesses, infections, or unusual symptoms during pregnancy: _________
   If yes, please explain: ____
   ____

2. If mother was taking medication during pregnancy, please list name of medication (s):
   ____

3. Was mother x-rayed during pregnancy. (Exclude sonogram) ❑YES ❑ NO.
   If yes, give month of pregnancy and type of x-ray___________________________________
   ____

4. Did mother have any bleeding, accidents, or injuries during pregnancy? ______________
   If yes, please give details: ____

5. Mother's general health during pregnancy:_______________________________________
   ____

6. Was mother under the care of a physician during pregnancy? ❑YES ❑ NO

7. Did physician attend the birth of applicant? _________. If yes, provide name and
   address of physician:

Physician’s name	Name of Hospital	Hospital ’s address

8. Did mother have problems with any of the following during labor?
( ) Excessive bleeding ( ) Fever ( ) Convulsions

9. Was applicant a full term baby? _____. If no, what month of gestation did birth occur? ___________.

10. Was there anything unusual about delivery? _________ Was birth Caesarean? ________ Cord prolapsed? ________ About the neck? _________ If other, please explain:_______
____

11. Birth weight: ____________________

12. Did applicant have any difficulties during first two weeks of life? ______ Was there any difficulty in getting applicant to breath immediately after delivery?______ Was there anything unusual in the appearance of applicant immediately after birth?______. If yes, please explain: ____
____

13. At what age were applicant’s difficulties noted? ___________
Please describe the changes that were first noted: _________________________________
____
____

14. Was test made for Phenylketonuria (PKU)? ________ Result: ____________________
__________ Hypothyroidism_________ Result: _________________________________

15. Have you ever had difficulty in feeding the applicant or getting him/her to eat?________
If yes, please explain: ____
____

16. At what age was the applicant able to do the following:

<u>Physical Development</u>:
Stand alone ____________ Walk unassisted_____________

<u>Language development</u>:
Babble_________Say single words_______ Say several words _______ Say 2 or 3 word phrases _________

17. Other comments or important information:
____

X. EVALUATION (S)

PLEASE PROVIDE THE FOLLOWING INFORMATION:

AGENCY/ADDRESS	NAME OF EVALUATION	DATE OF EVALUATION

XI. SIGNATURES:

Client (if over 18 years of age)

Parent or Legal Guardian

Person Completing Application

Date