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

_____
For Office Use Only

_____

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
( ) Other (Client's own words:)_____
_____

( ) ICF/MR Community Home
( ) Residential (Center Based)
( ) Long Term (Active)
( ) Holding (Inactive)
( ) Short Term (Respite)
( ) Assistive Technology Evaluation

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:

Physical Development:
Stand alone _____ Walk unassisted_____

Language development:
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