APPLICATION FOR SERVICES
MISSISSIPPI INTELLECTUAL/DEVELOPMENTAL DISABILITIES PROGRAMS

HUDSPETH REGIONAL CENTER

P. O. Box 127-B
Whitfield, MS 39193
(601) 664-6130; fax: (601) 354-6143

Please complete ALL of the following information as it relates to the person for whom services are being sought.

A. IDENTIFYING INFORMATION:			
Applicant – please complete the following in relation to the applicant			
Name in Full:			
First	Middle	Last	
Preferred Name:			
Street Address:	**City:**	**State:**	**Zip:**
Mailing Address:	**City:**	**State:**	**Zip:**
County:			
Date of Birth:	**Age:**	**Gender:**	**Race:**
Marital Status:	**Social Security #:**		
Home Phone:	**Cell Phone:**		
Work Phone:	**Email address:**		
Fax:	**Other (specify):**		
What is the best way to contact applicant? (circle one)	**home phone**	**cell phone**	**work phone**
text message	**email**	**fax**	**other (explain)**
Alternate phone or email if we cannot reach applicant at the above numbers:			
Length of residence in Mississippi	**How many people live in the home?**		
Person Completing Application – please complete the following in relation to the person completing the application			
Name in Full:			
First	Middle	Last	
Is Person Completing Application (circle one):	**Self**	**Legal Representative**	
Other (explain):			
Street Address:	**City:**	**State:**	**Zip:**
Mailing Address:	**City:**	**State:**	**Zip:**
County:			
Home Phone:	**Cell Phone:**		
Work Phone:	**Email address:**		
Fax:	**Other (specify):**		

What is the best way to contact the person completing the application? (circle one)			
home phone	**cell phone**	**work phone**	
text message	**email**	**fax**	**other (explain)**
Alternate phone or email if we cannot reach the person completing the application at the above numbers:			

B. CURRENT SITUATION:

Correspondent's name:	**Phone #:**
Correspondent's relationship with applicant:	
Who referred you?	
Why is application being made at this time? Explain:	

What services are you interested in? Check all that apply:

_____IDD Community Support Program (1915i)
_____ID/DD Waiver
_____Residential Placement
_____Community Living Services
_____Vocational Services
_____Other/Explain: ____

Are you seeking services in (circle all that apply): Institutional Setting Home/Community Setting

Who is caring for applicant now?

Is applicant currently receiving any services? If so, check all that apply and provide description and contact information:

_____Early Intervention	Description:
Address:	
Phone #:	
_____School	Description:
Address:	
Phone #:	
_____Community Mental Health Center	Description:
Address:	
Phone #:	
_____Day Program	Description:
Address:	
Phone #:	
_____Employment Related Services	Description:
Address:	
Phone #:	
_____Community Living	Description:
Address:	
Phone #:	
_____Home Health	Description:
Address:	
Phone #:	

______Physical Therapy	Description:
Address:	
Phone #:	
______Occupational Therapy	Description:
Address:	
Phone #:	
______Speech Therapy	Description:
Address:	
Phone #:	
______Private Duty Nursing	Description:
Address:	
Phone #:	
______Elderly and Disabled Waiver	Description:
Address:	
Phone #:	
______Independent Living Waiver	Description:
Address:	
Phone #:	
______Traumatic Brain Injury/ Spinal Cord Injury Waiver	Description:
Address:	
Phone #:	
______Assisted Living Waiver	Description:
Address:	
Phone #:	
______Hospice	Description:
Address:	
Phone #:	
______Other/Explain:	
Address:	
Phone #:	

C. SKILLS, ABILITIES AND BEHAVIOR:
Does applicant walk independently? No Yes
Does applicant use crutches? No Yes
Does applicant use canes? No Yes
Does applicant use a wheelchair? No Yes
Does applicant use a scooter? No Yes
Is applicant limited to bed? No Yes
Does applicant use the restroom without assistance?
Is applicant continent of bowel? No Yes
Is applicant continent of bladder? No Yes
Does applicant see well? No Yes
Wear glasses? No Yes
Wear contacts? No Yes

Does applicant have vision impairments that limit reading or travel? No Yes		
Does applicant have little or no functional vision? No Yes		
Does applicant hear normally? No Yes		
Wear hearing aids? No Yes		
Does applicant have little or no functional hearing? No Yes		
Does applicant feed him/herself? No Yes		
Does applicant require support with eating? No Yes		
If so, circle one of the following:		
No support	Minimal support	Total support
Does applicant use a nasogastric or gastrostomy feeding tube? No Yes		
How does applicant attend to personal grooming needs? Circle answer:		
No support	Minimal support	Total support
How does applicant communicate? Circle all that apply:		
words	gestures	sounds
eyes	communication device	sign language	facial expression
Other(explain):		
If the applicant speaks, is speech easily understood?		
Does applicant dress/undress self? No Yes		
Explain.		
Does applicant do simple chores around the house? No Yes		
If yes, explain:		
Is applicant hurtful to self? No Yes		
If yes, explain:		
Is applicant hurtful to others? No Yes		
If yes, explain:		
Does applicant destroy property? No Yes		
If yes, explain:		
Does applicant have disruptive behavior? No Yes		
If yes, explain:		
If applicant has disruptive behavior, does it occur in (circle all that apply):		
School	Home	Community
Does applicant have unusual or repetitive habits? No Yes		
If yes, explain:		
Does applicant display socially inappropriate behavior? No Yes		
If yes, explain:		
Does applicant have withdrawn/inattentive behavior? No Yes		
If yes, explain:		
Does applicant have temper tantrums? No Yes		
If yes, explain:		
Does applicant have behaviors that show he/she does not want to do as asked? No Yes		

If yes, explain:
Does applicant have any other problematic behavior not listed above? No Yes
If yes, explain:
Can applicant read? No Yes
If yes, how well?
Can applicant write? No Yes
If yes, how well?
Can applicant count? No Yes
If yes, how well?
D. SERVICE AND VOCATIONAL HISTORY:
Has the family ever consulted/been seen by anyone about these issues before now?
If so, by whom? Name:
When? From (beginning date) To (ending date)
Where?
If so, by whom? Name:
When? From (beginning date) To (ending date)
Where?
Has applicant ever had a psychological evaluation?
If so, by whom? Name:
When? Date:
Has applicant ever been admitted to a medical hospital, psychiatric hospital, or institution for individuals with intellectual disabilities?
Name of Hospital/Institution:
Address:
Street Address City State Zip
From (beginning date): To (ending date):
Reason for hospitalization:
Name of Hospital/Institution:
Address:
Street Address City State Zip
From (beginning date): To (ending date):
Reason for hospitalization:
Name of Hospital/Institution:
Address:
Street Address City State Zip
From (beginning date): To (ending date):
Reason for hospitalization:
Has applicant ever been employed?
Name of Employer:
Address:
Street Address City State Zip
From (beginning date): To (ending date):

Name of Employer:		
Address:		
Street Address City State Zip		
From (beginning date): To (ending date):		
Name of Employer:		
Address		
Street Address City State Zip		
From (beginning date) To (ending date)		
What is applicant's school history? Please list schools attended and dates of attendance:		
School/Address	Dates of Attendance	Highest Grade Reached
Did applicant participate in special educational services? No Yes		
If so, What was applicant's special education ruling? (e.g., specific learning disability, intellectual disability)		
Did applicant complete formal education? No Yes		
If yes, what year?		
Did applicant receive (circle the one that applies): diploma certificate of completion		
Was applicant ever removed from school? Explain:		
Has applicant received additional services besides the ones listed above?		
If yes, list below.		
Circle type of services received: psychiatric educational vocational residential medical		
Provider Name:		
Address:		
Contact #:		
Description of service:		
From (beginning date) To (ending date)		
Circle type of services received: psychiatric educational vocational residential medical		
Provider Name:		
Address:		
Contact #:		
Description of service:		
From (beginning date) To (ending date)		
Circle type of services received: psychiatric educational vocational residential medical		
Provider Name:		
Address:		

Contact #:	
Description of service:	
From (beginning date)	To (ending date)
List applicant's medical diagnoses:	
List applicant's current physician(s):	
Has applicant ever had a seizure? No Yes	
If yes, at what age?	
Has applicant continued to have seizures? No Yes	
If yes, how often?	
Has applicant ever had a serious accident or injury? No Yes	
If yes, explain:	
Does applicant have allergies to food, medication, etc.? No Yes	
If yes, explain:	
If so, for how long?	
List medications the applicant currently takes:	
Name of Medication:	
Dosage:	Frequency:
Medication type (circle one): prescription	non-prescription:
Prescribing physician:	
Reason prescribed:	
Name of Medication:	
Dosage:	Frequency:
Medication type (circle one): prescription	non-prescription:
Prescribing physician:	
Reason prescribed:	
Name of Medication:	
Dosage:	Frequency:
Medication type (circle one): prescription	non-prescription:
Prescribing physician:	
Reason prescribed:	
Name of Medication:	
Dosage:	Frequency:
Medication type (circle one): prescription	non-prescription:
Prescribing physician:	
Reason prescribed:	
Name of Medication:	
Dosage:	Frequency:
Medication type (circle one): prescription	non-prescription:

Prescribing physician:	
Reason prescribed:	
E. DEVELOPMENTAL HISTORY	
Where was applicant born?	
City:	**State:**
Hospital:	
Were there any illnesses, infections, or unusual symptoms during pregnancy? No Yes	
If yes, please explain:	
Was applicant under a physician's care during pregnancy? No Yes	
If yes, for how long (in months)?	
List medication mother took during pregnancy and reason:	
Name of Medication:	
Medication type (circle one): prescription non-prescription:	
Reason:	
Name of Medication:	
Medication type (circle one): prescription non-prescription:	
Reason:	
Name of Medication:	
Medication type (circle one): prescription non-prescription:	
Reason:	
Has applicant been exposed to drugs? No Yes	
If yes, was it during mother's pregnancy? No Yes	
If yes, was it after mother's pregnancy? No Yes	
Has applicant been exposed to alcohol? No Yes	
If yes, was it during mother's pregnancy? No Yes	
If yes, was it after mother's pregnancy? No Yes	
Has applicant been exposed to tobacco? No Yes	
If yes, was it during mother's pregnancy? No Yes	
If yes, was it after mother's pregnancy? No Yes	
Explain applicant's mother's general health during pregnancy?	
Was applicant a full-term baby? No Yes	
If no, in what month did birth occur? (1-9)	
Was labor (circle one) Spontaneous Induced	
Did applicant's mother have any of the following during birth? (circle those that apply)	
excessive bleeding convulsions/seizures attempts made to stop labor	
Was anything unusual about the delivery? No Yes	
If yes, explain:	
Was birth Cesarean? No Yes	
Was the cord around applicant's neck? No Yes	

Did applicant breathe immediately after birth? No Yes
If no, explain:
Was there anything unusual about the applicant that was noted at birth? No Yes
If yes, explain:
Birth weight: Birth length:
Did physician attend birth? No Yes If yes, Name of physician:
Was applicant born in a hospital? No Yes If yes, name of hospital:
Did applicant go to the NICU? No Yes
If yes, why?
For how long (# of days)?
Was genetic testing conducted? No Yes
If yes, what were the results?
Did applicant receive early intervention services? No Yes
If yes, who was the provider:
Length of service (in years):
Services provided:
At what approximate age did applicant do the following?

	Years	Months		Years	Months
Follow objects with eyes			Hold head up		
Roll over			Babble		
Sit alone			Say "Mama" or "Dada" with meaning		
Walk independently			Talk		
Crawl			Feed self		

F. FAMILY INFORMATION:
Are applicant's biological parents married to each other?
Date of marriage: Date of Separation: Date of Divorce:
Are the biological parents related to each other? No Yes
If yes, explain:
Applicant's father:
Name of applicant's father:
Date of birth: Age at birth of applicant:
Is applicant's natural father deceased? No Yes
If yes, what is the date of death?
Age of death? Cause of death?
Street Address: City: State: Zip:
Primary telephone #: Other phone #:
Address of birthplace: Street Address: City: State: Zip:

Marital Status (check one):
_____Married to applicant's natural parent
_____Divorced from applicant's natural parent
_____Never married to applicant's natural parent - Married
_____Never married to applicant's natural parent - Not Married
_____Remarried
_____Widowed

Highest Level of Education Completed (check one):
_____None
_____Elementary
_____Middle
_____High School
_____Undergraduate
_____Graduate

Current Occupation:

Current Place of Employment:

Is applicant's father a current or former military employee? No Yes

If yes, indicate branch of service:

Service number: **VA Number:**

Current health status (circle one): Good Fair Poor

Explain if fair or poor:

Is there a history of any of the following in the natural father's family?

Intellectual Disability? No Yes

If yes, check which relative:
_____Natural Mother
_____Maternal Grandfather
_____Maternal Grandmother
_____Maternal Aunt
_____Maternal Uncle
_____Maternal Cousin

Short History:

How It Affects Applicant:

Developmental Disability? No Yes

If yes, check which relative:
_____Natural Mother
_____Maternal Grandfather
_____Maternal Grandmother
_____Maternal Aunt
_____Maternal Uncle
_____Maternal Cousin

Short History:

How It Affects Applicant:

Psychiatric Disorder? No Yes

If yes, check which relative:
_____Natural Mother
_____Maternal Grandfather
_____Maternal Grandmother
_____Maternal Aunt
_____Maternal Uncle
_____Maternal Cousin

Short History:

How It Affects Applicant:

Cancer? No Yes

If yes, check which relative:
_____Natural Mother
_____Maternal Grandfather
_____Maternal Grandmother
_____Maternal Aunt
_____Maternal Uncle
_____Maternal Cousin

Short History:

How It Affects Applicant:

Applicant's mother:

Name of applicant's mother:

Date of birth: **Age at birth of applicant:**

Is applicant's natural father deceased? No Yes

If yes, what is the date of death?

Age of death? **Cause of death?**

Street Address: **City:** **State:** **Zip:**

Primary telephone #: **Other phone #:**

Address of birthplace:
Street Address: **City:** **State:** **Zip:**

Marital Status (check one):
_____Married to applicant's natural parent
_____Divorced from applicant's natural parent
_____Never married to applicant's natural parent - Married
_____Never married to applicant's natural parent - Not Married
_____Remarried
_____Widowed

Highest Level of Education Completed (check one):
_____None
_____Elementary
_____Middle
_____High School
_____Undergraduate
_____Graduate

Current Occupation:

Current Place of employment:
Is applicant’s mother a current or former military employee? No Yes
If yes, indicate branch of service:
Service number: VA Number:
Current health status (circle one): Good Fair Poor
Explain if fair or poor:
Is there a history of any of the following in the natural mother's family?
Intellectual Disability? No Yes
If yes, check which relative: _____Natural Mother _____Maternal Grandfather _____Maternal Grandmother _____Maternal Aunt _____Maternal Uncle _____Maternal Cousin
Short History:
How It Affects Applicant:
Developmental Disability? No Yes
If yes, check which relative: _____Natural Mother _____Maternal Grandfather _____Maternal Grandmother _____Maternal Aunt _____Maternal Uncle _____Maternal Cousin
Short History:
How It Affects Applicant:
Psychiatric Disorder? No Yes
If yes, check which relative: _____Natural Mother _____Maternal Grandfather _____Maternal Grandmother _____Maternal Aunt _____Maternal Uncle _____Maternal Cousin
Short History:
How It Affects Applicant:

Cancer? No Yes

If yes, check which relative:
_____Natural Mother
_____Maternal Grandfather
_____Maternal Grandmother
_____Maternal Aunt
_____Maternal Uncle
_____Maternal Cousin

Short History:

How It Affects Applicant:

Household:

Please list all other people living in the household.

Name	Date of Birth	Age	Gender	Relationship

Adoption Information (complete if applicable)s:

Date of adoption: **Age of applicant at time of adoption:**

Date applicant placed with adoptive parents:

Adoption agency:

Adoptive mother's name: **Date of birth:**

Address:

Phone #: **Social Security #:**

Current health status (circle one): Good Fair Poor

Explain:

Occupation: **Current employer:**

Adoptive father's name: **Date of birth:**

Address:

Phone #: **Social Security #:**

Current health status: Good Fair Poor

Explain:

Occupation: **Current employer:**

Applicant's siblings:

List applicant's siblings including those deceased. Also note any miscarriages or stillborns.

Name	Date of Birth	Age	Health/Mental Status (good, fair, poor)

Siblings, cont.			
Name	Date of Birth	Age	Health/Mental Status (good, fair, poor)
Explain any mental health or medical conditions noted in siblings:			

G. REPRESENTATIVE INFORMATION

Name in Full:			
First	Middle	Last	
Relationship to Applicant (circle one): spouse	parent/stepparent	child/stepchild	
other relative	physician	case manager	self
other (specify):			
Home Phone:	**Cell Phone:**		
Work Phone:	**Email address:**		
Fax:	**Other (specify):**		
What is the best way to contact you? (circle one)	home phone	cell phone	work phone
text message	email	fax	other (explain)
Alternate phone or email if we cannot reach you at the above numbers:			
Street Address:	**City:**	**State:**	**Zip:**
Mailing Address:	**City:**	**State:**	**Zip:**
County:			

Is Representative Any of the Following? (check all which apply)

_____Guardian of person
_____Guardian of property
_____Current surrogate
_____Current representative payee
_____Current power of attorney contact
_____Current durable power of attorney contact
_____Current case manager or service coordinator contact
_____Current physician
_____Current emergency contact

Explain:

H. FINANCIAL INFORMATION:

Does applicant receive benefits from:

SSI?	**Amount:**	**Payee:**
SSDI?	**Amount:**	**Payee:**
VA Benefits?	**Amount:**	**Payee:**
Other?	**Amount:**	**Payee:**

Does applicant have Medicaid? No Yes If yes, provide Medicaid #:

Does applicant have medical insurance other than Medicaid?
If so, indicate whether applicant has:
Medicare #:
CHAMPUS:
Private Health Insurance:
Monthly income of applicant:
Monthly income of parents:
LEGAL GUARDIANSHIP/CONSERVATORSHIP:
Applicants over the age of 18 are considered to be competent adults unless legal guardianship/ conservatorship have been obtained through the courts.
Has a legal guardian/conservator been appointed by the court?
Name of legal guardian/conservator:
Address of legal guardian/conservator:
Date legal guardianship/conservatorship appointed:
If legal guardianship/conservatorship has been appointed, court documents must be returned with this application for services.

I certify that the information provided in the application for services is complete and accurate to the best of my knowledge.

Signature of Person Seeking Services — Date

Signature of Person Completing Application — Date

Signature of Father — Date

Signature of Mother — Date

Signature of Legal Guardian/Conservator — Date