

[illegible]

GESTATION, BIRTH, AND NEONATAL HISTORY:

If there were any accidents, injuries, illnesses, infections, or unusual symptoms during pregnancy, explain:

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

List medication mother took during pregnancy and reason:

How was mother's health during pregnancy?

Was applicant exposed to alcohol, drugs, or tobacco during pregnancy?

Was applicant born full-term?

If not, what month?

Was labor spontaneous?

Induced? Why?

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

Excessive bleeding?

Convulsions/Seizures?

Attempts made to stop labor?

Fever?

If yes, give details:

Was birth Cesarean?

Explain:

Was anything unusual about the delivery?

Was the cord around applicant's neck?

Was there any difficulty in getting applicant to breathe immediately after birth? Explain:

Was there anything unusual noticed about the applicant immediately after delivery? Explain:

Birth weight:

Birth length:

Did physician attend birth?

Name of physician:

Was applicant born in a hospital?

Name of hospital:

Did applicant go to the NICU? If so, why?

Was genetic testing conducted?

Results:

DEVELOPMENTAL HISTORY:

At what age did applicant do the following?

Follow objects with eyes:

Hold head up:

Roll over:

Babble:

Sit alone:

Stand alone:

Crawl:

Walk independently:

Feed self:

Say "mama" or "dada" with meaning?

Talk:

Does applicant have difficulty walking independently?

Does applicant use crutches?

Wheelchair?

Other aids?

Does applicant use the restroom without assistance? Explain.

Is applicant continent of bladder?

Is applicant continent of bowel?

Does applicant require support with eating? Explain.

Does applicant use a nasogastric or gastrostomy feeding tube?

How does applicant communicate?

words

gestures

sign language

facial expression

sounds

communication device

Other:

ABILITIES AND BEHAVIOR:

Does applicant dress/undress self? Explain.

How does applicant attend to personal grooming needs? Circle answer:

independently

with minimal support

with moderate support

with total support

Does applicant do simple chores around the house? Explain.

Is applicant hurtful to self?

Is applicant hurtful to others?

Does applicant destroy property?

Does applicant have disruptive behavior?

Does applicant have socially inappropriate behavior?

Does applicant have unusual or repetitive habits?

Does applicant have withdrawn/inattentive behavior?

Does applicant have temper tantrums?

Does applicant have uncooperative behavior?

Explain any of the above:

Has applicant received mental health services? If yes, explain.

Does applicant currently receive mental health services? If yes, where?

Has applicant been prescribed medication for mental health concerns? If yes, explain.

How well can applicant read?

How well can applicant write?

How well can applicant count?

List schools attended and dates of attendance:

School/Address

Dates of Attendance

Highest Grade Reached

Did applicant participate in special educational services?

Ruling:

Did applicant complete formal education and receive a diploma or certificate of completion?

If yes, what year?

Was applicant ever removed from school? Explain:

VOCATIONAL/EMPLOYMENT HISTORY:

Please list any vocational training and/or employment for applicant:

Name/Address of Program/Employer

Dates of Attendance

Has applicant received services through the Mississippi Department of Rehabilitation Services or Ability Works? If yes, please provide dates of service:

MEDICAL INFORMATION:

List applicant's medical diagnoses:

List applicant's current physician(s):

Has applicant ever had a seizure?

At what age?

Has applicant continued to have seizures?

How often?

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

Has applicant been exposed to drugs, alcohol, or tobacco?

Has applicant been hospitalized?

Name of Hospital

Dates of Service

Reason for Hospitalization

Does applicant have allergies to food, medication, etc.?

Has applicant undergone surgery? If yes, explain.

Does applicant see adequately?

Wears glasses/contacts?

Does applicant hear adequately?

Wears hearing aids?

List all current medications:

Name of Medication

Dosage

Frequency

Prescribing Physician

Reason Prescribed

Please list previous medications prescribed:

Does applicant require administration of medication in a specialized manner?

Does applicant smoke cigarettes or use other tobacco products?

Does applicant drink alcoholic beverages? If so, amount and frequency.

BIOLOGICAL FAMILY INFORMATION:

Are applicant's biological parents married to each other?

Date of marriage:

Separation:

Divorce:

Are the biological parents related to each other? Explain:

Applicant's father:

Name of applicant's father:

Date of birth:

City/State of birth:

If applicant's father is deceased, give date and cause:

Complete address:

Primary telephone #:

Other phone #:

Age at birth of applicant:

Social Security #:

Number of years of education completed:

1 2 3 4 5 6 7 8 9 10 11 12

Number of years college/vocational training:

1 2 3 4 5 6 7 8

Occupation:

Current employer:

Branch of military:

Retired?

Current health status:

Good

Fair

Poor

Explain:

List names/date of other marriages:

Paternal grandfather's name:

Paternal grandmother's name:

Is there a history of any of the following in the applicant's father's family? Circle all that apply:

Intellectual disability

Mental health disorder

Seizure disorder

Developmental disability

Cancer

Venereal disease

Explain:

Applicant's mother:

Name of applicant's mother:

Maiden:

Date of birth:

City/State of birth:

If applicant's mother is deceased, give date and cause:

Complete address:

Primary telephone #:

Other phone #:

Age at birth of applicant:

Social Security #:

Number of years of education completed:

1 2 3 4 5 6 7 8 9 10 11 12

Number of years college/vocational training:

1 2 3 4 5 6 7 8

Occupation:

Current employer:

Branch of military:

Retired?

Current health status:

Good

Fair

Poor

Explain:

List names/date of other marriages:

Maternal grandfather's name:

Maternal grandmother's name:

Is there a history of any of the following in the applicant's mother's family? Circle all that apply:

Intellectual disability

Mental health disorder

Seizure disorder

Developmental disability

Cancer

Venereal disease

Explain:

Adoption Information:

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:	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	Address (if not in home)	Health/Mental Status (good, fair, poor)
Explain any mental health or medical conditions noted in siblings:				

HOUSEHOLD:				
Please list all other people living in the household.				
Name	Date of Birth	Age	Gender	Relationship

FINANCIAL INFORMATION:

Does applicant receive benefits from:

SSI?

Amount:

Social Security?

Amount:

Other?

Amount:

Provide policy number if applicant has any of the following medical insurance?

Medicaid #:

Medicare #:

Other:

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

AUTHORIZATION TO DISCUSS PROTECTED HEALTH INFORMATION (PHI)

This form authorizes Hudspeth Regional Center (HRC) to discuss protected health information (PHI) of persons served by HRC Diagnostic Services. This authorization is voluntary. You may revoke this authorization at any time by writing to Hudspeth Regional Center Diagnostic Services, P. O. Box 127-B, Whitfield, MS 39193. The authorization will remain in effect until revoked.

SECTION 1: NAME OF PERSON SERVED BY HRC DIAGNOSTIC SERVICES (Please print and complete all information)

Name: _____

Date of birth: _____

SECTION 2: PERSONAL REPRESENTATIVE

If you are acting on behalf of the person listed in Section 1, you are the person's Personal Representative and you must complete this section.

Print Name of Personal Representative:

Signature of Personal Representative:

What is your relationship to the person listed in Section 1? (choose more than one if applicable)

☐ Parent

☐ Primary caretaker

☐ Legal Guardian

☐ Conservator

☐ Non-relative primary caretaker

☐ Other (describe) _____

If available, please include a copy of one of the following documents as proof of legal representation:

☐ Valid health care proxy

☐ Certificate of Guardianship

☐ Letter of incapacity from the physician of the person listed in Section 1

SECTION 3: TO WHOM IS HRC DIAGNOSTIC SERVICES AUTHORIZED TO DISCUSS THE PROTECTED HEALTH INFORMATION (PHI) OF THE PERSON BEING SERVED BY HRC DIAGNOSTIC SERVICES?

1. _____

2. _____

3. _____

4. _____

5. _____

SECTION 4: SIGNATURE

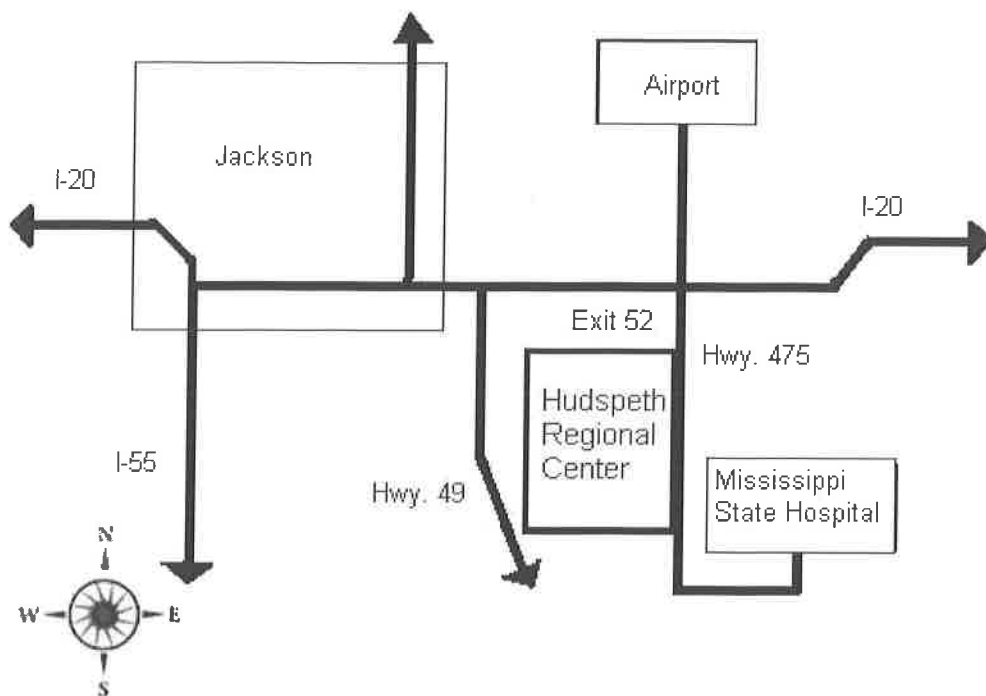
I understand that if the entity with whom HRC Diagnostic Services is authorized to discuss my PHI is not a health plan, health care provider or other covered entity as described by the HIPAA Privacy Rule, the released information may no longer be protected by federal privacy laws, rules and regulations. I understand that the information discussed may include mental health information. I understand that I am not required to sign this form, but if I do sign this form, it will be considered valid until revoked. I understand that I may revoke this authorization at any time by notifying HRC Diagnostic Services in writing. I agree that this information is true and correct. I sign this authorization under penalties of perjury and attest that HRC Diagnostic Services may rely on my signature and the contents of this authorization.

Signature

Date: _____

If you need help in filling out this form, please call the HRC Diagnostic Services Department at (601) 664-6132.

Directions to Hudspeth Regional Center



If you are coming from Hwy. 49 South (Gulf Coast), I-55 North (Memphis), or I-55 South (New Orleans), take I-20 East towards Meridian. Take Exit 52 and go South (right). There will be signs indicating the International Airport and Whitfield before you get to the exit. After you turn right, go approximately 3 miles and turn right. You will see a sign on the right of the highway indicating Hudspeth Regional Center.

If you are coming from I-20 EAST (Meridian), take Exit 52 and go South (left). There will be signs indicating the International Airport and Whitfield before you get to the exit. After you turn left, go approximately 3 miles and turn right. You will see a sign on the right of the highway indicating Hudspeth Regional Center.

If you are coming from I-20 West (Vicksburg) take Exit 52 and go South (right). There will be signs indicating the International Airport and Whitfield before you get to the exit. After you turn right, go approximately 3 miles and turn right. You will see a sign on the right of the highway indicating Hudspeth Regional Center.

Physical Address: 100 Hudspeth Center Dr. Whitfield, MS 39193

When you turn into HRC, you will go through a guard gate. Tell the police at the gate that you are coming to Diagnostic Services. Once you get onto the campus, one of the first buildings you will see is the administration building. You can park in a visitor parking space in front of the building. Come through the double glass doors and tell the receptionist that you are coming to Diagnostic Services. She will let us know that you are here.

Authorization/Consent to Release or Obtain Protected Health Information

Client/Patient Name: _____ Case Number: _____

Race: _____ Sex: _____ Date of Birth: _____

Social Security Number: _____

Authorized Personal Representative (if applicable): _____

I, _____ or I, _____ as the personal representative,

hereby authorize **Hudspeth Regional Center, P.O. Box 127-B, Whitfield, MS 39193**

to release or obtain (circle) my protected health information/records to/from: _____

I specifically authorize/consent to the release or obtaining (circle) of health information/records pertaining to the following:

Please indicate by initialing and/or describing the amount and type of health information to be obtained/released):

- ☐ Medication Records
☒ Medical History and Physical Examination(s)
☐ Physicians Orders/Notes
☐ X-ray and/or Lab Records
☒ Evaluations for (list area(s): psychology, medical/nursing, education, etc.)
☒ psychology, medical/nursing, education, etc.
☐ Treatment Plans and Related Revisions, Progress Notes and Summaries for (list area(s): psychology, medical/nursing, education, etc.)
☐ Entire Health Information Record
☐ Other (Describe other information/records to be disclosed/obtained)

for the specific purpose of: **Diagnostic Information**
(Describe purpose or nature of the information to be disclosed/obtained.)

Dates of service for which the information/record is requested or will be released:

From: **Initial** To: **Present**

I understand that this authorization/consent will be effective on _____ date of signature
and (effective mo/day/year)

will expire on _____ one year from date of
signature
(Indicate mo/day/year, event, or condition, not to exceed one year)
and cannot be renewed without my written authorization/consent.

I understand that I have the right to revoke this authorization at any time. I understand that to revoke this authorization, I must provide a specific request to revoke the authorization in writing to (department)

D&E of (agency) **Hudspeth Regional Center**

I understand that my revocation will not apply to action or any information that has already been released/obtained in response to this authorization.

I understand that my authorizing the disclosure/obtaining of this health information is voluntary. I understand that I need not sign this form in order to receive treatment. I understand that I may inspect or copy information to be used or disclosed as provided for by law. I understand that any disclosure of information carries with it the potential for a redisclosure and that the information may no longer be protected by federal confidentiality laws. If I have questions about disclosure of my health information, I can refer to the center's Notice of Privacy Practices for Protected Health Information or contact Tina Hester, privacy officer at Hudspeth Regional Center.

(Signature of Client/Patient, if applicable) _____ (Date) _____

(Signature of Parent/Guardian/Judicially Authorized Representative, if applicable) _____ (Date) _____

(Attach or include description of such representative's authority to act for the client/patient, if applicable.)

(Signature of Witness, if applicable) _____ (Date) _____

Note to Person(s) Receiving Information addressed in this authorization:

This information has been disclosed to you from records, the confidentiality of which is protected by state and/or federal law(s) or regulations. These laws/regulations prohibit you from making further disclosure of this information without the specific written authorization/consent of the person to whom it pertains or of other persons as permitted by law. A general authorization for the release of medical or other information is not sufficient for this purpose.

**HUDSPETH REGIONAL CENTER
DIAGNOSTIC SERVICES DEPARTMENT**

CONSENT FOR EVALUATION FORM

I hereby authorize that _____ may be evaluated by the Diagnostic Services Department at Hudspeth Regional Center using professional staff, consultants, interns, practicum students, or other evaluators designated by and deemed appropriate by the facility. I understand that the evaluation may include an assessment of any or all of the following as deemed appropriate: intellectual/cognitive abilities, adaptive behavior, maladaptive behavior, achievement, communication, vision, and hearing. I also understand that portions of the evaluation may rely on informant report.

I understand this evaluation may be observed by staff and practicum students from other departments at Hudspeth Center and by other persons deemed appropriate by the facility.

Person (if 18 years of age and ruled independent)

Date

Parent or legal guardian

Date

Responsible party

Date

Witness

Date

HUDSPETH REGIONAL CENTER

Acknowledgment of Receipt of Notice of Privacy Practices

Date that Notice of Privacy Practices and Acknowledgment of Receipt of Notice were sent or given to Individual Client/Patient/Authorized Representative: _____

Name of Individual Client/Patient: _____

Case Number (if applicable): _____

I acknowledge that I have received the **Notice of Privacy Practices for Hudspeth Regional Center**, effective April 14, 2003.

Signature of Individual Client/Patient or Authorized Personal Representative

Date

Please return this form to:

Hudspeth Regional Center
Diagnostic Services
P.O. Box 127-B
Whitfield, MS 39193