APPLICATION FOR SERVICES
MISSISSIPPI INTELLECTUAL/DEVELOPMENTAL DISABILITIES PROGRAMS

HUDSPETH REGIONAL CENTER

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

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 mother 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

HUDSPETH REGIONAL CENTER

Notice of Privacy Practices for Protected Health Information (PHI)

THIS NOTICE DESCRIBES HOW MEDICAL/HEALTH INFORMATION ABOUT YOU OR ABOUT THE INDIVIDUAL FOR WHOM YOU ARE AN AUTHORIZED PERSONAL REPRESENTATIVE MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THE INFORMATION. PLEASE REVIEW IT CAREFULLY.

Hudspeth Regional Center is dedicated to protecting your medical information. Hudspeth Regional Center is required by law to maintain the privacy of your protected health information and to provide you with this Notice of our legal duties and privacy practices with respect to protected health information. Hudspeth Regional Center collects health information from you and stores it in a chart or file and on a computer. This is your health record. The health record is the property of Hudspeth Regional Center, but the information in the record belongs to you. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. If you have questions about any part of this Notice or if you want more information about the privacy practices at Hudspeth Regional Center, please contact:

Privacy Officer
Hudspeth Regional Center
P.O. Box 127-B
Whitfield, MS 39193
Phone number: 601-664-6302

Effective Date of this Notice: April 9, 2014

Hudspeth Regional Center is required to abide by the terms of the Notice currently in effect.

Changes to the Notice: Hudspeth Regional Center reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all protected health information that we maintain. If Hudspeth Regional Center makes a material change in this Notice, we will post the revised Notice at the *center* and will make a copy of the revised Notice available to you upon request.

Section I: Description of how Hudspeth Regional Center may use or disclose your health information and examples of each.

The law permits Hudspeth Regional Center to use or disclose your health information without your written consent or authorization for the following purposes:

Treatment: We may use health information about you to provide treatment and services. We may disclose your health information to doctors, nurses, technicians, or other staff at Hudspeth Regional Center who are involved in taking care of you or when we refer you from Hudspeth Regional Center to another health care provider for treatment or services.

Examples: Your physician may ask a nurse to give you certain medications or information related to your condition or treatment. Another example is that if you had heart problems that required us to consult with a heart specialist (cardiologist) outside of the center, your doctor at the *center* may refer you to a cardiologist in the community for your care. The *center* would share information from your health record needed by the staff at the cardiologist's office for your continued care. We may also release your information to another treatment facility for your continued care after your discharge from this facility.

Payment: We may use and disclose your health information to third party payers, such as insurance companies, Medicaid, or Medicare, when needed to determine your eligibility for benefits, for reimbursement, or for other requirements related to payment for treatment or services.

Examples: Information on or accompanying a bill to your insurance company or a claim form to the Division of Medicaid may include information, such as your diagnosis, the dates you received the services for which payment is requested or claimed, and the procedures or services you received. Information may be disclosed and used as part of utilization review activities, such as precertification and preauthorization of services and concurrent and retrospective review of services.

Healthcare Operations: We may use your health information for the purposes of Hudspeth Regional Center operations. These uses and disclosures are necessary to run or operate the *center* and to make sure that all individuals we serve receive quality care.

Examples: Your records may be copied by a secretary to send them to another healthcare provider for your continued treatment. Members of the medical/nursing staff and other staff at the *center* may review your health information to assess the care, outcomes, and quality of services you and others at the *center* receive.

Section II: Other purposes for which we are permitted or required to use or disclose your health information without your consent or authorization:

1. We may contact you to provide or remind you of an appointment, information about treatment alternatives, or other health related benefits and services that may be of interest to you. Examples of how we may contact you include:

   - Telephone calls (Messages to call the *center* may be left on an answering machine)
   - Written correspondence
   - Facsimile (fax)
   - Electronic mail
   - Written correspondence or telephone calls asking you to help identify what services might be beneficial to you, to ask about your satisfaction with our services, or to ask about your ongoing treatment after discharge.

2. We may disclose your health information to **you or your authorized personal representative**, except as restricted under applicable laws and regulations.

3. Information may be released about you for **public health activities**, such as:

   - To prevent or control diseases.
   - To report death.
   - To report abuse or neglect.
   - To track products as regulated by the federal Food and Drug Administration (FDA) and to report problems or reactions to medications or products.
   - To provide notification and communication about product recalls, replacements and look-backs.

4. Information may be released to **health oversight agencies for activities** authorized by law. These activities may include investigations, inspections and licensure, and other lawful activities. These activities may also include providing access to your health information on a need-to-know basis by members of the Human Rights Advocacy Committee for approved activities. All specific information gained by the Human Rights Committee shall remain confidential.

5. Information may be disclosed in the course of any **administrative or judicial proceeding**:

   1. In response to a court order.
   2. Under certain restricted circumstances, in response to a subpoena or a similar process.

6. Information may be disclosed for **law enforcement purposes** under certain circumstances, such as reporting of certain types of physical injuries, locating persons, and reporting and investigating of crimes.

7. Information may be disclosed to a **coroner, medical examiner, or funeral directors**, consistent with applicable law.

8. **If you are an organ, eye or tissue donor**, your health information may be disclosed to organizations involved in procurement, banking or transplantation to facilitate organ, eye
or tissue donation or transplantation.

9. Information may be disclosed for **public safety reasons** to appropriate persons in order to prevent or lessen a serious and/or imminent threat to the health or safety of a particular person or the general public.

10. Information may be disclosed as necessary to comply with **Workers Compensation** laws.

11. Information may be disclosed for **research purposes**, only as approved by the facility's research committee that serves as an Institutional Review Board and/or privacy board.

12. We may disclose your health information for other purposes as **required or permitted by law.**

Section III: Other Uses or Disclosures

1. Unless you object or we are otherwise restricted by law, we may disclose relevant health information about your location, your general condition, or in the event of your death, if it is needed to notify or assist in **notifying a family member**, your authorized personal representative or another person responsible for your care.

   If you are available and able to agree or object prior to our disclosing this information, we will provide you the opportunity to object or otherwise obtain your agreement prior to disclosing the information. If you are unable or unavailable to agree or object, our health professionals will use their best judgement to determine if disclosing the information to your family member or others involved in your care is in your best interest. If they decide that disclosure is in your best interest, they will disclose only the health information that is relevant and necessary to that person's involvement in your care.

Section IV: When Hudspeth Regional Center may not use or disclose your health information.

Except as provided in this Notice of Privacy Practices, Hudspeth Regional Center will not use, sell or disclose your health information for marketing purposes and, nor will we use or disclose, except under certain conditions, psychotherapy notes, without your written authorization. If you do authorize the *center* to use or disclose your information for purposes other than as provided in this Notice, you may revoke your authorization in writing at any time.

Section V: Your Health Information Rights

You have the following rights with respect to your Protected Health Information (PHI):

1. **The right to request restrictions on certain uses and disclosures of protected health information.** Hudspeth Regional Center is not required to agree to your requested restriction. If the *center* does agree to your requested restriction, we will comply with your request, unless the information is needed to provide you with emergency treatment.

2. **The right to receive confidential communications of protected health information.**

   You have the right to request in writing to the Privacy Officer that the *center* only communicate to you in a certain format (for example, in writing) and/or at a certain location (for example, only at your work address). We will accommodate all reasonable requests.

3. **The right to inspect and receive an electronic or paper copy of your protected health information**, subject to certain restrictions as provided for by law. You may be charged a fee for copying and/or postage.

4. **The right to amend protected health information.** You have a right to request that Hudspeth Regional Center amend or change your health information. Hudspeth Regional Center is not required to change your health information under certain conditions. You must make requests for amendments in writing and include the reason(s) for your request.

5. **The right to receive an accounting of disclosures of protected health information.** You have a right to receive an accounting of disclosures of your

health information made by the *center*, except for disclosures such as treatment, payment, healthcare operations, and certain other disclosures as provided for by law.

6. **The right to receive a paper copy of this Notice of Privacy Practices.** If you agreed to receive this Notice electronically, you also have the right to request a paper copy.

Section VI: How you can exercise your health information rights.

You may exercise one or more of the rights described in this Notice or receive additional information by contacting:

Privacy Officer
Hudspeth Regional Center
P.O. Box 127-B
Whitfield, MS 39193
Phone Number: 601-664-6302

Section VII: Complaints

If you believe your health information privacy rights have been violated, you may contact:

Privacy Officer
Hudspeth Regional Center
P.O. Box 127-B
Whitfield, MS 39193
Phone Number: 601-664-6302

Or, you may contact:

OCR Regional Manager
Office for Civil Rights
U.S. Department of Health and Human Services
Atlanta Federal Center, Suite 3B70
61 Forsyth Street, S.W.
Atlanta, GA 30303-8909

or

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 515F HHH Bldg.
Washington, D.C. 20201.

You will not be retaliated against for filing a complaint.

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

HUDSPETH REGIONAL CENTER

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
__X__ Medical History and Physical Examination(s)
_____ Physicians Orders/Notes
_____ X-ray and/or Lab Records
__X__ Evaluations for (list area(s): psychology, medical/nursing, education, etc.)

__X__ 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 offcer 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.

(Center staff must provide a copy of the signed authorization to the client/patient and/or judicially authorized representative.)

HUDSPETH REGIONAL CENTER

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
__X__ Medical History and Physical Examination(s)
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__X__ Evaluations for (list area(s): psychology, medical/nursing, education, etc.)

__X__ 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.)

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(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.

(Center staff must provide a copy of the signed authorization to the client/patient and/or judicially authorized representative.)

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.

_____ Date: _____

Signature

If you need help in filling out this form, please call the HRC Diagnostic Services Department at (601) 664-6130.

HUDSPETH REGIONAL CENTER
DIAGNOSTIC SERVICES DEPARTMENT

CONSENT FOR EVALUATION FORM

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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
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Parent or legal guardian	Date
_____	_____
Responsible party	Date
_____	_____
Witness	Date