Residential Services Screening Application
Central Mississippi Residential Center
701 Northside Drive, Newton, MS 39345
Census Director: Tina Bailey
Phone: 601-683-4260 | Fax: 601-683-4324

A. Identifying Information:

Full Name:							
Nickname:							
Birth Date:				Age:			
Social Security No.:				Birthplace:			
Current Address:							
State:			Zip Code:				
Home Phone:			Cell Phone:				
Mailing Address (if different):							
State:			Zip Code:				
How long have you lived in Mississippi:							
Sex:		Male		Female	Race:		
Marital Status:		Single/Never Married		Married		Separated	
		Divorced		Widowed			
Religious Preference:							
Emergency Contact Person's Name:							
Relationship:							
Address:							
Home Phone:				Work Phone:			
Cell Phone:							
Do you have a **legal** guardian or conservator?		Yes		No			
If **yes**, what is his or her Name and contact information?							
Address:							
Home Phone:				Work Phone:			
Cell Phone:							
Who referred you to CMRC?							

B. Psychiatric History:

Please list any **Psychiatric Admissions** to inpatient and outpatient agencies. Include treatment for Alcohol and/or Drug abuse.

Hospital or Facility	Approximate Date of Treatment

What are your **Current** Psychiatric Diagnoses?	
How old were you when you were first diagnosed or treated for Mental Illness?	

What drugs/substances have you used in the past?	
X	
	Alcohol
	Crack Cocaine
	Powder Cocaine
	Marijuana/Hashish
	Heroin/morphine
	Methadone
	Codeine
	Darvocet
	Lorcet/Lortab
	Oxycodone/Oxycontin
	Hydromorphone/Dilaudid
	Fentanyl
	LSD
	Methamphetamine/Speed/Crystal
	Amphetamine
	Ecstasy
	Ritalin
	Adderall
	Alprazolam/Xanax
	Diazepam/Valium
	Lorazepam/Ativan
	Aerosols/Inhalants
	Other:

Have you ever attempted suicide?		Yes		No
If 'Yes,' When and How?				

C. Medical History:

Please list any medical conditions (Diabetes, High Blood Pressure, etc.) you have.
Please list any surgeries you have had.

What are your **Current Medications**: (attach additional sheets if needed)	

Please list any **Medications** you are **allergic** to:	

Please list any **foods** you are **allergic** to:	

Do you have any visual problems?		Yes		No		
If yes, do you wear glasses or use other visual aids?		Yes		No		
Do you have a hearing impairment?		Yes		No		
If yes, do you use hearing aids or use an amplifier?		Yes		No		
Have you ever had a seizure?		Yes		No		

If yes, how old were you when the seizures started?	
How long ago was your most recent seizure?	
How often do you have seizures?	
What seizure medication, if any, are you taking?	

D. Abilities:

Are you able to walk without assistance?		Yes		No				
If No, please explain:								
Are you able to feed yourself without assistance?		Yes		No				
Do you have any problems with speech?		Yes		No				
Are you able to dress and undress yourself?		Yes		No		Partially		
Can you attend to personal grooming (bathing, brushing teeth, etc.)?		Yes		No		Partially		
Do you have any problems with sleep?		Yes		No				
What special talents or hobbies do you have?								
What kinds of activities do you enjoy?								

E. Residential Information:

Where are you living now?							
	Family home		Independent living		Group home		Personal care home
	Supported living/apartment		Homeless		Inpatient facility / State Hospital		
	Crisis Stabilization Unit		Other:				
How long have you been living there?							
Have you lived in any residential programs?			Yes		No		
If Yes, please list:							
Are you interested in Residential Services at CMRC?			Yes		No		
What are your needs? **What do you hope to accomplish at CMRC**?							

F. Educational/Vocational Information:

Are you currently employed?		Yes		No
What kind of work have you done in the past?				
How far did you go in school?		Years / Grades		
Do you have a GED?		Yes		No
Do you have a High School Diploma?		Yes		No
Did you attend College?		Yes		No
Have you had any Vocational training?		Yes		No

G. Social/Family History:

Marital status:		Single		Married		Separated		Divorced		Widowed
How Many Children do you have?				Sons				Daughters		
Who are the **Important People** in your life?										
Is there any family history of mental illness?				Yes				No		

Yes	No	**Trauma Checklist – Revised:** Please indicate if you have experienced any of the following:
		Serious accidents, fire or explosion:
		Natural disaster (tornado, flood, hurricane, major earthquake):
		Non-sexual assault (physically attacked / injured): | | Familiar | | Stranger
		Sexual assault : | | Familiar | | Stranger
		Military combat or war zone:
		Imprisonment:
		Life-threatening illness:
		Childhood sexual molestation / Abuse:
		Homelessness:
		Victim of stalking or bullying:
		Witness to another being seriously assaulted, injured or killed:
		Other (specify):

Have you ever been arrested?		Yes		No
If Yes, please explain:				

H. Financial Information:

Income / Resources						
Source/Amount of income:		SSI $		SSDI $		VA $
	Other Source and monthly amount:					$
Do you have a representative payee?		Yes		No	If yes, identify below:	
Name:				Relationship:		
Medicaid		Yes		No		
Medicare		Yes		No		
Medicare Part D		Yes		No		
Other Health Insurance		Yes		No		

I. Signatures:

_____ _____

Applicant Guardian (if applicable)

_____ _____

Person Completing Application Date