

**Superior Health Support Systems
Merlin Home
1703 Hyde St.
Sault Sainte Marie, MI 49783
Phone 906-259-7373 Fax 906-259-0558**

Resident Application

Applicant's Information:

Name _____ Gender: M /F Date: _____ Move in Date _____

Current Address _____ Phone _____

City _____ State _____ Zip _____ Date of Birth _____

Place of Birth _____ Age _____ Religion _____

Marital Status _____ Anniversary Date _____ Social Security Number _____

Medicaid # _____ Medicare # _____ Veteran # _____

U.S. Citizen _____ Residents Legal Status _____

Date of Last Physical & Chest X-ray _____ Code Status : Full _____ DNR _____

Current Living Arrangement _____

Reason for Admission _____

Preferred Funeral Home _____

Is Resident Able to: Write Letters _____ Sign Documents _____ Read/Understand Mail _____ Use Phone _____

Resident's Feeling's Toward Placement _____

Do You Believe Residents is a Danger to Self or Others? _____ Does Resident wander? _____

Can Resident Walk? _____ w/Walker _____ Cane _____ Wheelchair _____

SPEECH: Good _____ Understandable _____ Slurred _____ Mumbles _____ Grunts _____

VISION: Good _____ w/Glasses _____ Poor _____ Nearly Blind _____ Blind _____

HEARING: Good _____ Poor _____ Undetermined _____ Hearing Aids _____

Bladder/Bowel: Incontinent or Continent? _____ Currently wearing depends? _____

Other Information:

Physician's Name _____

Street Address _____

City _____ State _____ Zip _____ Telephone Number _____

Home Health Agency Name _____ Telephone Number _____

Children and Responsible party information:

NAME (including spouse)	ADDRESS	HOME/WORK NUMBER	RELATIONSHIP/TITLE
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1 _____

2 _____

3 _____

4 _____

Source of Payment:

Private _____ Other _____

Amount _____ Weekly _____ Monthly _____ Annually _____

Please send statement to:

NAME	RELATIONSHIP
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ADDRESS	PHONE
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Signature of Applicant/Responsible Party: _____

Print Name: _____ **Date:** _____

How did you learn about Superior Health Support System: The Merlin Home?

Newspaper _____ Radio _____ Physician _____

Current Resident/Family _____ Hospital/Other Facility _____

Family/Friends _____ Other _____

