Superior Health
Support Systems

Resident Application

Applicant's Information:

Name: _____ Gender: M / F Submission Date: _____ Current

Address: _____ City: _____ State: ____ Zip: _____ Phone:

_____ Date of Birth: _____ Social Security Number: _____ Place

of Birth: _____ Age: _____ Religion: _____

Marital Status: _____ Anniversary Date: _____ US Citizen: Y / N

Medicaid #: _____ Medicare #: _____ Veteran #: _____

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

Current Living Arrangement: _____

Reason for Admission: _____

Desired Move-in Date: _____ Preferred Funeral Home: _____

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

Resident's Feelings Toward Placement: _____

Do you believe resident is a danger to self or others: Y / N Does resident wander: Y / N

Resident Walks:
Independently ____ With: Walker ____ Cane ____ Wheelchair ____

Speech: Good ____ Understandable ____ Slurred ____ Mumbles ____

Teeth: Dentures on Top ____ Bottom ____ Both ____ Own Teeth ____ No Teeth ____

Vision: Good ____ Poor ____ Nearly Blind ____ Blind ____ Glasses: Y / N Hearing:

Good ____ Poor ____ Undetermined ____ Hearing Aids: Y / N

Bladder/bowel:Incontinent / Continent Currently wearing depends: Y / N

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Other Information:

Physician's Name: _____ Phone: _____ Street Address:

_____ City: _____ State: ____ Zip: _____ Home Health

Agency Name: _____ Phone: _____ Children and

Responsible Party Information:

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

1: _____

2: _____

3: _____

4: _____

Financial Information:

Income Sources/Amounts per month:

Social Security $_____ Pension $_____ Retirement Distributions: $_____

VA Benefit Payments $_____ Other (specify): _____ $_____ Financial

Responsible Party / Please send invoices and statements to:

Name: _____ Relationship: _____ Phone: _____

Street Address: _____ City: _____ State: ____ Zip: _____

Signature of Applicant / Responsible Party: _____

Print Name: _____ Date: _____

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Home Preference - please list from 1 to 5 with 1 being your top choice of home:

____ Hearthside Assisted Living (Sault Ste Marie, MI)

____ Merlin Home (Sault Ste Marie, MI)

____ Pennington Home (Pickford, MI)

____ Harborview Assisted Living (DeTour, MI)

____ White-Wiles Home (Rudyard, MI)

How did you learn about Superior Health Support Systems?

- ☐ Newspaper
- ☐ Radio
- ☐ Facebook
- ☐ Physician
- ☐ Mailer
- ☐ Current SHSS Resident/Family:
- ☐ Hospital/Other Facility: _____
- ☐ Family/Friends: _____
- ☐ Other _____

*******PLEASE SUBMIT YOUR COMPLETED APPLICATION PACKET AND DEPOSIT TO THE BUSINESS OFFICE*******

Located at: 308 W 12th Avenue Sault Sainte Marie, MI 49783

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SCREENING QUESTIONAIRE

Name:_____

Current Living Arrangement:
Please check all that apply:
I live: _____ in my own home/apartment
_____ senior housing
_____ with spouse
_____ with friend/significant other
_____ with family members
_____ alone

Care Needed:
Please check all that apply:

1.Bathing
____ Preparation/Set up
____Getting in/out of shower
____Other
2. Ambulation ____Cane ____Walker ____ Wheelchair ____Other
3. Wake up/Get out of bed
___need to be awakened
___Help to get out of bed
___Dressing/undressing
___Fasten clothes
___socks/shoes
___complete assistance
4. Preparing for bed ___getting ready ___getting into bed
5. Incontinence ___use protective garments ___need help to change
6. Special Diet
___Diabetic
___Low sodium
___Low fat
___Vegetarian
___Other_____

7. Dining
___special utensils
___assistance getting ready
___assistance to get to and from dining room
___likes to sit alone
___likes to sit with others

Concerns about you:
Please list all current physical conditions you have (cancer, hypertension, etc.)

Do you have a doctor caring for any of these conditions? _____

Have you been diagnosed with dementia or Alzheimer's? YES_____ NO_____

Do you have trouble with forgetting things?_____

Are you nervous or anxious around other people?_____

Are you shy about getting to know strangers?_____

What are your favorite foods to eat?_____

What time of the day do usually eat meals and snacks?_____

List any other things you think are pertinent to your caregivers to make this residence your home, a place where you feel very welcome, comfortable and peaceful.

_____
_____
_____

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308 W 12th Avenue
Sault Ste. Marie, MI 49783
Phone: (906) 259-0647
Fax: (906) 259-0648
office@shsseup.com HR@shsseup.com

ACH Authorization

I (we) hereby authorize Superior Health Support Systems, hereinafter called SHSS, to initiate debit entries for ACH (Automated Clearing House) to my (our) account indicated below and the financial institution named below, hereinafter called Financial Institution, to debit the same to such account. I (we) acknowledge the origination of ACH transactions to my (our) account must comply with the provisions of US law.

Financial Institution Name: _____

Branch: _____

Address:_____

Routing Number: _____ Account Number:_____

Account Type: ☐ Checking ☐ Savings ☐ Loan

Amount of Debit: ☐ Balance due on payment date
☐ $_____

Start Date: _____

Frequency: ☐ One Time Payment
☐ Monthly payment on the _____ day of the month

This authority is to remain in full force and effect until SHSS has received written notification from me (or either of us) of its termination in such time and manner as to afford SHSS and their banking institution a reasonable opportunity to act on it.

Print Resident Name:_____

Print Signer's Name: _____

Signature: _____ Date: _____

To terminate this ACH Origination Authorization, written notice must be received by SHSS (Mailing address: 308 W 12th Avenue, Sault Ste Marie, MI 49783)