This information is needed to evaluate the applicants request for admission.
Please complete this form to the best of your ability and return to:

Holy Martyrs Chaldean Catholic Church
43700 Merrill Road
Sterling Heights, MI 48314
(586) 803-3114

All information will be considered by the admissions committee and will be held in strict confidence.
You have to be able to live safely in this independent setting.
These apartments are available for persons 55 years and older.
The acceptance of this form does not bind either part to admission.

Apartment preference: ☐ One bedroom ☐ Two bedroom
☐ One bedroom deluxe ☐ One bedroom deluxe plus

Floor: ☐ 1st ☐ 2nd ☐ 3rd

Name: First____________________ Middle_________________Last_______________________

Address: Street____Apt._______________________

City________________________________ State___________ Zip Code____________

Sex: ☐ M ☐ F Social Security Number:_____-____-______ Telephone: (____) _____-______

Age: _______ Date of Birth: _______-_______-_______

Present Marital Status: ☐ Single ☐ Married
☐ Widowed ☐ Divorced

Name of Spouse: First________________ Middle________________ Last ___________________

Social Security Number: ______-______-_______

Person(s) to contact in case of necessity:

Name	Relationship	Address	Telephone
__________________	________________	_______________________	___________________
__________________	________________	_______________________	___________________
__________________	________________	_______________________	___________________

____________________ __________________ __________________________ _____________________

Person responsible for payments (lease, utilities, etc.)

Name: First________________________________ Last____________________________________

Address: Street____ Apt.______________

City_________________________ State______________ Zip Code____________________

Telephone: Cell (_______) __________-______________ Other (______) __________-_____________

Legal guardian and/or power of attorney:

Name: First________________________________ Last____________________________________

Address: Street____ Apt.______________

City_________________________ State______________ Zip Code____________________

Telephone: Cell (_______) __________-______________ Other (______) __________-_____________

Personal Physician:

Name: First________________________________ Last____________________________________

Address: Street____ Apt.______________

City_________________________ State______________ Zip Code____________________

Telephone: Cell (_______) __________-______________ Other (______) __________-_____________

General State of Health: (List any major health problems we should be aware of)

____

____

____

List allergies, if any ____

Do you care for your personal needs? ____

Do you require a special diet? ____

List daily medications: ____

Persons responsible for providing transportation for various doctor appointments and other needs:

Name: First________________________________ Last________________________________

Telephone: Cell (_______) __________-______________ Other (______) _________-_________

Name: First________________________________ Last________________________________

Telephone: Cell (_______) __________-______________ Other (______) _________-_________

Medical Insurance: ☐ Medicare ☐ Medicaid ☐ Private Insurance

Company Name______________________________ Additional Information
Policy Number_______________________________ __________________________________
Hospital preference:

____

Do you have a will? ☐ Yes ☐ No
If yes, who has knowledge of its safekeeping? ____

Additional Comments and Remarks:

____
____
____
____

The above information is complete and correct to the best of my knowledge.

____ _________________________
Applicant's Signature Date

____ _________________________
Responsible Person's Signature (if applicable Date Received

Application received by: ____