St. Michael's HEALTH GROUP

FENWYCK HEIGHTS
Resident Application Form

Applicant Last Name(s)		
Applicant First Name(s)		
Current Address		
City/Town		**Prov**
Postal Code	**Date of Birth** *dd/mm/yy*	
Email Address		
Primary Phone #		**Alternative Phone #**

1st Alternate Contact Name		
Relationship to Applicant		
Contact Address		
City/Town	**Prov**	**Postal Code**
Email Address		
Primary Phone #		**Alternative Phone #**

2nd Alternate Contact Name		
Relationship to Applicant		
Contact Address		
City/Town	**Prov**	**Postal Code**
Email Address		
Primary Phone #		**Alternative Phone #**

Suite Type	**□ Studio**	**□ 1 Bedroom**	**□ 1 Bedroom w/Terrace**	**□ 1 Bedroom Premium**	**□ 1 Bedroom Premium w/Terrace**
	□ 2 Bedroom	**□ 2 Bedroom Premium**	**□ 2 Bedroom Premium w/Terrace**	**□ 2 Bedroom Passage**	**□ 2 Bedroom Premium Passage**

How soon are you looking to move in?		
Do you have a vehicle and require parking?	**□ Yes**	**□ No**
Do you smoke?	**□ Yes**	**□ No**
Are you currently receiving home care services?	**□ Yes**	**□ No**

I understand that there will be a review by St. Michael's Health Group during which time an assessment of my/our capabilities and needs will be carried out. Submitting of application does not guarantee acceptance.

Applicant's Signature _____ Date _____

Party Responsible for Applicant
(if applicable)
Signature _____ Date _____

Manager's Signature _____ Date _____