

**CASA SERENA**  
ENTE ITALIANO CASA ANZIANI  
ITALIAN OLD AGE HOMES FOUNDATION  
**APPLICATION FORMS FOR ADMISSION**

Name \_\_\_\_\_ Surname (maiden) \_\_\_\_\_ (married) \_\_\_\_\_

Date of birth \_\_\_\_\_ Place of birth (town) \_\_\_\_\_ Province \_\_\_\_\_

State \_\_\_\_\_ Nationality (state if dual) \_\_\_\_\_

I.D. \_\_\_\_\_ Passport \_\_\_\_\_ (Copy attached?) \_\_\_\_\_

Marital status \_\_\_\_\_ Spouse name \_\_\_\_\_ Children \_\_\_\_\_

Addresses of children \_\_\_\_\_  
\_\_\_\_\_

Telephone Numbers \_\_\_\_\_

Other family members \_\_\_\_\_ Tel \_\_\_\_\_

1) \_\_\_\_\_

2) \_\_\_\_\_

Priority contact in case of emergency \_\_\_\_\_

Family Doctor name \_\_\_\_\_ Tel \_\_\_\_\_

Medical Aid \_\_\_\_\_ Number \_\_\_\_\_ Main member \_\_\_\_\_

Medical card submitted to medical personnel? \_\_\_\_\_

Hospital card submitted to medical personnel? \_\_\_\_\_

Funeral Plan \_\_\_\_\_ Funeral directors \_\_\_\_\_ No choice \_\_\_\_\_

Hospital Plan \_\_\_\_\_ Plan No. \_\_\_\_\_ Hospital preference \_\_\_\_\_

Choice of Room \_\_\_\_\_ Frail Care \_\_\_\_\_ Date \_\_\_\_\_

Signature Resident ..... Signature Guarantor .....