



LYNGBLOMSTEN APARTMENTS
1455 ALMOND AVENUE - ST. PAUL, MN 55108
www.lyngblomsten.org

Applicant _____ **Birthdate** _____
Address _____ **City** _____ **State** _____ **Zip** _____
Phone # () _____ **Social Security #** _____

Co-Applicant _____ **Birthdate** _____
Address (if different from above) _____
Phone # _____ **Social Security #** _____

Name of Church Congregation _____

Do you need the features of an accessible unit? _____

Have you ever lived in government subsidized housing? _____

If so, when _____

Name and address of development _____

Has your assistance ever been terminated because of fraud, non-payment of rent, or other reasons? _____

If yes, explain _____

List names, addresses and phone numbers of relatives or friends who would know how to reach you in case we could not reach you.

Name _____ **Relationship** _____
Address _____ **City** _____ **St** _____ **Zip** _____
Home Phone _____ **Work Phone** _____

Name _____ **Relationship** _____
Address _____ **City** _____ **St** _____ **Zip** _____
Home Phone _____ **Work Phone** _____

The following information will be verified by our office using a third party:

Monthly rent paid _____ **Monthly utility costs** _____ (excluding phone)

of bedrooms _____ **# of occupants** _____ **Do you have a waterbed?** _____

Do you have a pet? _____

REFERENCES:

Present Landlord _____ **Phone** _____ **How long there** _____

Previous Landlord _____ **Phone** _____ **How long there** _____

CREDIT REFERENCES:

Company Name _____ **Account #** _____

Company Name _____ **Account #** _____

ASSET & INCOME INFORMATION

ASSET INFORMATION

Current cash value on all assets is required.

	Value/Total on Deposit	% Rate/Yearly Income
Savings	_____	_____
Checking	_____	_____
Stocks	_____	_____
Bonds	_____	_____
Home/ Real Estate	_____	_____
IRA	_____	_____
OTHER	_____	_____
OTHER	_____	_____

MONTHLY INCOME INFORMATION

Social Security Amount	_____
Pension Amount	_____
Monthly Annuity Income	_____
Monthly Wages	_____
Other Monthly Income	_____

MEDICAL EXPENSE INFORMATION (BASED ON LAST YEAR'S FIGURES)

*Please note that some of this is monthly and some of this is annual amounts.
These figures should only include amounts paid out of pocket for recurring medical expenses.*

Monthly Medicare deduction	_____
Monthly supplemental Medical Insurance Premiums	_____
Twelve months of Prescription costs	_____
Twelve months of Dental expenses	_____
Any other medical expenses please list separately:	_____

ALL APPLICATIONS MUST BE FILLED OUT COMPLETELY AND SIGNED TO BE VALID.

I certify that all statements made in the application are true and complete to the best of my knowledge. I understand that any statements or information are reason for rejection of this application.

Signature of Applicant _____ **Date** _____

Signature of Co-Applicant _____ **Date** _____

