PAL Humane Society
The Historic Apple Valley Inn
20601 Hwy. 18 #156
Apple Valley, CA 92307
(760) 240-6848

ASSISTANCE DOG APPLICATION

Part One

APPLICATION INFORMATION

Application Checklist:

- ☐ Completed application part one and two
- ☐ Recent photograph of yourself
- ☐ Autobiography (please use separate sheet)
- ☐ $50.00 application donation (non-refundable)

If any of the above items are not included in your packet, PAL will not be able to process your application. Please remember to make certain that all the required documents are received by PAL.

Application: Include your **$50 Application donation (Non-refundable) with your completed application.** Please provide us with an autobiography. **You may be required to travel to PAL's for 12 days of Training.**

No person will be denied the opportunity to be considered as a recipient because of limited financial ability.

Interview: You will be contacted to meet with PAL staff to further determine your needs and qualify you for the placement of an Assistance Dog.
An Interview donation of $150.00 (Non-refundable) will be due on the day of the interview.

Placement: **There are no additional charges for the dog.** Once a potential match has been identified, you will be notified and invited to Partner Training where you will meet and learn to work with your new partner. The applicant is *encouraged* to contribute towards a portion of the cost of preparing the service dog during the two years it is in the training program. This can be done via personal donations, business sponsorships etc. PAL staff will assist you with fundraising opportunities.

Please send all applications to:

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FOR OFFICE USE ONLY

DATE RECEIVED _____/_____/_____ **RECEIVED BY:** _________________________

ITEMS MISSING:____

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ASSISTANCE DOG APPLICATION

PERSONAL INFORMATION

Name: ______________________________

Address: ______________________________

City __________ State: ______ Zip: ________ County: __________

Birth Date: __________ Phone #: __________ Cell #: __________

Email Address: ______________________________

Place of Employment: ______________________________

Work Address: ______________________________

City __________ State: ______ Zip: ________ County: __________

Nearest Relative Name: ______________________________

Relationship: ______________________________

Address: ______________________________

City __________ State: ______ Zip: ________ County: __________

How did you hear about PAL Humane Society? ______________________________

____

____

What is your disability? ______________________________

____

How long have you been disabled? ______________________________

---

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PERSONAL INFORMATION (Check all that apply)

Print Name: ____

☐ Married ☐ Single ☐ Children: #_______ Ages: ________________

☐ Divorced ☐ Separated ☐ Widowed

I live in a: ☐ House ☐ Apartment ☐ Other: ________________

I live with: ☐ Parents ☐ Spouse ☐ Group

☐ Alone ☐ Number of residents in home: _____________

My home has a: ☐ Fenced yard ☐ Enclosed Area

My other pets include: ☐ Dogs # _____ ☐ Cats #_____ ☐ Birds #______

Breeds & Gender ____

You must be able to travel to PAL. Can you? ☐ Yes ☐ No

If no, please give a reason: ____

Do you currently receive government benefits? ☐ Yes ☐ No

☐ SSI: $____________ ☐ SSDI: $____________ ☐ Other: $ ______________

Monthly income (other than government benefits) $______________

Do you ☐ Rent or ☐ Own your home? Amount of Rent/Mortgage per month $_______

Check all that apply: ☐ Work at home ☐ work outside home ☐ attend school

Please describe work/school environment: ____

____

____

Describe your activity level: ☐ Low ☐ Moderate ☐ High

Explain: ____

____

____

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PERSONAL INFORMATION (Continued)

Print Name: ____

Please describe your home life, social life, hobbies, and your lifestyle as a whole:

____

____

____

Please describe your house and yard: ____

____

____

Please list, in order of importance, the tasks you would like your dog to perform for you:

____

____

____

Please describe all means of transportation that you use ____________________________

____

____

Are you able to travel and deal with the time and expense away from home for two weeks of Partner Training?: ☐ Yes ☐ No (If No, please explain)

____

____

What kinds of adaptive equipment do you routinely use: ____________________________

____

____

Please describe the animals currently living in your home: (if any) ____________________

____

____

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PERSONAL INFORMATION (Continued)

Print Name: ____

Please describe your knowledge of dog care: ____________________________

____

____

Please describe your knowledge of dog behavior: ____________________________

____

____

Please describe how you will deal with your assistance dog when he sheds, has fleas, or needs veterinary care and food. How will you pay for these costs?

____

____

What characteristics do you like in a dog? ____________________________

____

What characteristics do you dislike in a dog? ____________________________

____

In what ways do you feel you will need to change your lifestyle to meet the physical and psychological needs of your Assistance Dog?

____

____

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PERSONAL INFORMATION (Continued)

Print Name: ____

We ask that you contact your local service clubs (Elks, Lions, Rotary, etc.) for possible sponsorships. Are you willing to do this?: ☐ Yes ☐ No (If No, please explain)

____

____

PAL HUMANE SOCIETY, INC. ANTI-DISCRIMINATION CLAUSE

It is the policy of PAL to extend equal consideration and treatment to all persons regardless of race, color, national origin, religion, creed, gender, sexual orientation, martial status, age, or physical or mental disabilities or medical conditions.

PAL reserves the right to deny services to an applicant if it can be determined that the individual's special circumstances or requirements could result in the unsafe handling of the dog or may cause undue hardship, personal injury to the handler or endanger the safety of the general public.

____ ____________________________

APPLICANT SIGNATURE **DATE**

IF APPLICANT IS A MINOR, UNDER GUARDIANSHIP OR CONSERVATORSHIP OR A WARD OF THE COURT, THE PARENT OR DULY AUTHORIZED REPRESENTATIVE IS REQUIRED TO SIGN BELOW PURSUANT TO STATE AND FEDERAL LAW.

Print Name: ____

Relationship, Title, or Agency: ____

Address: ____

City: ______________________________ State: ____________ Zip: ______________

Phone Number (_____) ______________ OR (_____) ________________________

____ ____________________________

SIGNATURE **DATE**

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ASSISTANCE DOG APPLICATION
PART TWO

APPLICANT MEDICAL HISTORY RELEASE FORM

Print Name: ____

I authorize the release of any requested information regarding my health to PAL Humane Society. The information given will not be used for any other purpose than to evaluate and assess my condition as it relates to making successful canine placement. PAL will keep this information confidential and will not share it with anyone but the professional staff involved in helping provide services for me.

________________________________ ____________________
Applicant's Signature Date

If the applicant is a minor, under guardianship of conservatorship, or a ward of the court, the parent or duly authorized representative is required to sign below pursuant to state and federal law.

Sign name: __________________________ Print name: __________________________

Relationship, Title or Agency: ____

Address: ____

City: _______________________ State: _________________ Zip: ________________

Phone Number: (_____)___________________ Date:________________________

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Part two

Professional Reference Report

THIS FORM IS TO BE COMPLETED BY YOUR PHYSICIAN

Print Patient's Name: ____

Doctor's Name: ____

Doctor's Address: ____

City: ______________________ State: _____________ Zip: _____________

Date of last visit: ________________________

How long have you been associated with this patient? ____________________

Please give prognosis and list the effects of your client's disability relating to the individual's ability to engage in activities of daily living (ADL). These include the ability to attend personal care needs such as feeding, toileting, dressing, and managing finances, maintaining home and attaining needed outside services.

Mental/ Emotional Evaluation of Client:

1. Does your client have the ability to exercise judgment and make decisions necessary for ADL?
   ☐ Yes ☐ No

2. Does your client possess the ability of memory and perception necessary for ADL?
   ☐ Yes ☐ No ☐ Minimally

3. Does your client have the ability to sustain a reasonable attention span?
   ☐ Yes ☐ No

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4. Is your client taking any medications in which it impairs normal functioning? ☐ Yes ☐ No
   If yes, what?
   ____
   ____
   ____
   ____
   ____
   ____

5. Does your client demonstrate inappropriate behavior that is beyond his/her control?
   ☐ Yes ☐ No ☐ Minimally

   If yes, please explain:
   ____
   ____
   ____

6. Does your client possess the ability to learn and follow directions to the degree necessary to sustain ADL? ☐ Yes ☐ No ☐ Minimally

7. Is your client able to make decisions concerning his/herself as well as others needs and safety?
   ☐ Yes ☐ No ☐ Minimally

8. Is your client's disability due to or affected by alcoholism, drug use or abuse? ☐ Yes ☐ No

   If yes, please complete the following:

a) Has your client ever been accepted into a treatment facility? ☐ Yes ☐ No

   If yes, when: ____

b) Has your client ever refused treatment or a referral to a treatment center? ☐ Yes ☐ No

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c) Is your client capable of making rational decisions? ☐ Yes ☐ No

d) Does your client present a danger to him/herself or others? ☐ Yes ☐ No

9. Do you recommend this client for an assistance dog? ☐ Yes ☐ No

10. May we contact you for more information or clarification? ☐ Yes ☐ No

11. Additional Comments:

____
____
____
____
____
____
____
____
____
____

______________________________ ______________
Signature of Professional Date

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MEDICAL HISTORY REPORT

Current Physical Status:

1. Visual Impairment: ☐ Yes ☐ No

   If yes, please describe:
   ____
   ____
   ____

Uncorrected Vision: Right: ____________________ Left: ____________________

Corrected Vision: Right: ____________________ Left: ____________________

2. Hearing Impairment: ☐ Yes ☐ No

   If yes, please describe:
   ____
   ____
   ____

   Right: ____________________ Left: ____________________

3. Speech Impairment: ☐ Yes ☐ No

   If yes, please describe:
   ____
   ____
   ____

4. Cardiac System Involvement: ☐ Yes ☐ No

   If yes, please describe in detail. Include such information as use of pacemaker, monitor, arrhythmias, murmurs, history of cardiac arrest or congestive heart failure, circulation deficiencies, etc:
   ____
   ____
   ____

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5. Renal system involvement: ☐ Yes ☐ No

   If yes, please describe in detail, including whether or not patient requires dialysis, type of dialysis, and frequency:

   ____

   ____

   ____

6. Respiratory system involvement: ☐ Yes ☐ No

   If yes, please describe in detail, including history of respiratory arrest or insufficiency:

   ____

   ____

   ____

   ____

   ____

7. Seizures: ☐ Yes ☐ No

   If yes, please describe, including cause (if known) type, frequency of occurrence, duration and integral since last seizure:

   ____

   ____

   ____

   ____

8. Learning Disabilities: ☐ Yes ☐ No

   If yes, please describe:

   ____

   ____

   ____

   ____

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9. Mental and Emotional status.

Does patient exhibit any of the following?
Awareness of surroundings: ☐ Yes ☐ No
Appropriate orientation: ☐ Yes ☐ No
Appropriate attention span: ☐ Yes ☐ No
Ability to relate positively with others: ☐ Yes ☐ No
Ability to communicate ideas clearly: ☐ Yes ☐ No
Ability to follow, absorb and incorporate sequenced instructions: ☐ Yes ☐ No
Ability to form insights, judgments and to plan course of action: ☐ Yes ☐ No

If there are any "No" answers to Question 9 above, please explain.

____

____

10. Mental and Emotional Status.

Memory Impairment: ☐ Yes ☐ No
Prior history of institutionalization: ☐ Yes ☐ No
History of substance abuse: ☐ Yes ☐ No

If there are any "Yes" answers to Question 12 above, please explain:

____

____

11. Medications:

Please list all medications currently prescribed, dosage, conditions requiring medications and anticipated response to the medication. Please, also indicate possible side effects:

____

____

____

____

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Restrictions and Recommendations for Patient during Partner Training:

Partner Training involves a minimum of two weeks of intensive training. A significant amount of physical exertion is required of the participant while learning the skills necessary to using an assistance dog. As training progresses, participants are required to make trips to local malls and other locations. These trips are necessary for the participant to learn to use his/her dog in public.

While Partner Training is physically and emotionally demanding, the support a dog will provide after placement will greatly reduce the amount of energy the recipient must expend each day. Time, effort, and emotional commitment are necessary to the formation of successful recipient/assistance dog team.

Please list any restrictions you feel should apply to this patient during Partner Training:

____

____

____

____

PHYSICIAN'S STATEMENT:

It is my opinion that this patient is physically, mentally, and emotionally able to participate in Partner Training for an assistance dog. I believe that such a placement would contribute to his/her independence.

____ ________________
Physician's Signature Date

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