



My Angel With Paws, Inc.

**A non-profit organization
Raising, Training and Placing Service Dogs and Therapy Dogs**

Service Dog Application

APPLICATION INFORMATION:

Be certain to include all of the following materials when submitting your application.

- Completed application
- Medical Necessity form completed by your physician
- Provide a recent close up photograph of yourself
- Autobiography (please use separate sheet)

Once your complete application has been received, a home visit will be scheduled to complete the application process. If accepted, you will be placed on a waiting list until a potential match is found. The “waiting time” for this match will vary depending on the availability of dogs able to fulfill your particular needs. When a potential match is found, a Partner Trainer Educator will begin working with you to prepare you for Partner Training, a two week intensive training period with you and your dog. At the end of Partner Training you will be expected to pass a Public Access Test prior to taking your new partner home.

If any of the above items are not included in your, My Angel With Paws will be unable to process your application. Please make certain that all the required documents are filled out completely. Use a separate paper if needed.

Please send all applications to:

**My Angel With Paws, Inc.
3098 Marsh Road
Deland, Florida 32724**

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

MY ANGEL WITH PAWS, INC.

3098 Marsh Road
Deland, Florida 32724
(386) 490-4949

Date Received: _____
Items Missing: _____

Date Complete: _____

APPLICATION

(Please print)

Applicant Personal Information		
Applicant Name	Home Phone	Cell Phone
Address		
City, State, Zip		
Email	Marital Status: Single Married Divorced Other	
DL#	Work Phone	
Employer	Occupation	
Address		
City, State, Zip		
Guardian Information (If Client is a Minor)		
Name(s)	Home Phone	Cell Phone
Address		
City, State, Zip		
Email	SS#	
Marital Status: Single Married Divorced Other	Spouse Name	
Employer	Position/Title	
Address		
City, State, Zip		
Emergency Contact (Other than above)		
Name	Home Phone	Cell Phone
Relationship		
Address		
City, State, Zip		

What is your disability? _____

Medical History of Applicant:

Medical Diagnosis:

Age of onset: _____ Years with disabilities: _____

Do you have a caregiver or medical attendant? _____

If so, how often do they come and give medical attention and what do they do:

Do you use a cane, walker or wheelchair? Yes _____ No _____

Please describe in detail: _____

Do you participate in rehabilitation or therapy? Please describe: _____

Do you drive? YES _____ NO _____

If so what make of vehicle: _____

Please describe all your activity level, activities and hobbies: _____

Service Dog Requirements

Type of dog you applying for: **Service** **Mobility** **Companion** **Therapy**

Would your Service Dog accompany you everywhere? YES _____ NO _____

What qualities do you need in a Service Dog? _____

What tasks do you need in a Service Dog?

Could you provide the dog with veterinary care, heart worm preventive, flea control, grooming, exercise and feeding?
YES _____ NO _____

If you are unable to do the daily tasks of feeding and care of the Service Dog, who would be the one to help you with the dog?

Please circle the correct answer:

I live in a: House Apartment Other: _____

I live with: Parents Spouse Group home Alone

My home has a: Fenced yard Enclosed Area

Please, describe your house and yard: _____

My other pets include: Dogs # _____ Breeds & Gender _____

Cats # _____ Birds # _____ Other: _____

Children in home: # _____ Ages: _____

Monthly income (other than government benefits) \$ _____

Do you rent or own your home? Rent Own

Amount of Rent/Mortgage per month \$ _____

1) Circle all that apply: Work at home Work outside home Attend school Other

Please describe work/school environment:

Please describe your expectations of the "perfect" Service Dog and how it could help your quality of life.

Anything else you would like for us to consider in reference to you obtaining a Service Dog?

MY ANGEL WITH PAWS, INC. ANTI-DISCRIMINATION CLAUSE

It is the policy of My Angel With Paws, Inc. 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. My Angel With Paws, Inc. 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 or care 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 (_____) _____ Cell(_____) _____

SIGNATURE

DATE

APPLICANT MEDICAL HISTORY RELEASE FORM

Print Name: _____

I authorize the release of any requested information regarding my health to My Angel With Paws, Inc. 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. My Angel With Paws, Inc. 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.

Print name: _____

Relationship, Title or Agency: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: (____) _____ Date: _____

Authorized Signature **Date**

Professional Reference Report

THIS FORM IS TO BE COMPLETED BY YOUR PHYSICIAN

Print Patient's Name: _____

Physician Name: _____

Physician 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 patient'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 patient:

1. Does your patient have the ability to exercise judgment and make decisions necessary for ADL?

Yes No Minimally

2. Does your patient possess the ability of memory and perception necessary for ADL?

Yes No Minimally

3. Does your patient have the ability to sustain a reasonable attention span?

Yes No Minimally

4. Is your patient taking any medications in which it impairs normal functioning? Yes _____ No _____

If yes, what medications?

5. Does your patient demonstrate inappropriate behavior that is beyond his/her control?

Yes No Minimally

If yes, please explain:

6. Does your patient possess the ability to learn and follow directions to the degree necessary to sustain ADL?

Yes No Minimally

7. Is your patient able to make decisions concerning his/herself as well as others needs and safety?

Yes No Minimally

8. Is your patients' disability due to or affected by alcoholism, drug use or abuse? Yes_____No_____

If yes, please complete the following:

a) Has your patient ever been accepted into a treatment facility? Yes_____ No_____

If yes, when and where?

b) Has your patient ever refused treatment or a referral to a treatment center? Yes_____ No_____

c) Is your patient capable of making rational decisions? Yes_____ No_____

d) Does your patient present a danger to him/herself or others? Yes_____ No_____

9. Do you recommend this client for an assistance dog? Yes_____ No_____

If yes, please explain how you feel a service dog will mitigate your patients' disability, in turn providing a better quality of life.

May we contact you for more information or clarification? Yes_____ No_____

11. Additional Comments:

Signature of Physician

Date

MEDICAL HISTORY REPORT

THIS FORM IS TO BE COMPLETED BY YOUR PHYSICIAN

Current Physical Status

1. Visual Impairment: Yes _____ No _____

If yes, please describe:

2. Hearing Impairment: Yes _____ No _____

If yes, please describe:

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:

5. Renal system involvement: Yes _____ No _____

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 interval since last seizure:

8. Learning Disabilities: Yes _____ No _____

If yes, please describe:

9. Mental and Emotional status

A. Does patient exhibit any of the following?

B. Awareness of surroundings: Yes _____ No _____

C. Appropriate orientation: Yes _____ No _____

D. Appropriate attention span: Yes _____ No _____

E. Ability to relate positively with others: Yes _____ No _____

F. Ability to communicate ideas clearly: Yes _____ No _____

G. Ability to follow, absorb and incorporate sequenced instructions: Yes _____ No _____

H. 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.

- A. Memory Impairment: Yes_____ No _____
- B. Prior history of institutionalization: Yes_____ No _____
- C. History of substance abuse: Yes_____ No _____

If there are any "Yes" answers to Question 10 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:

Restrictions and Recommendations for Patient during Team 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 a service 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/service dog team.

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

PHYSICIAN'S STATEMENT:

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

Physician's Signature

Date