



# H.O.P.E. for Animals Application for Wellness and Surgery Assistance

We do not offer assistance for chronic illness or emergency situations.

Please contact a full service veterinarian if your pet needs immediate care.

**\*\*Applications submitted without proof of income will not be approved\*\***

**Instructions:** 1. Please complete this application, AND attach proof of income ( ie: Disability statement, SSI statement, unemployment statement, or tax return). If you do not have any of these documents contact H.O.P.E. at 260-420-7729 for clarification. Approval of Assistance Applications can take up to **10** business days. You must fill out this form each time you need assistance services through our Assistance Program. Application valid for 30 days from approval date. *One approved application per household per year.*

2. Return your application AND proof of income by mail, fax, or email to:

**Address: 1333 Maycrest Drive, FW, IN 46805**

**Email: info@hfafw.org**

**Fax: 260-444-2395**

Owner Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email: \_\_\_\_\_

**LIST ALL PETS IN YOUR HOME-EVEN IF SERVICES ARE NOT NEEDED FOR EACH ANIMAL. ATTACH ADDITIONAL LIST IF NECESSARY:**

Pet Name: _____	Age: _____	(Please Circle) <u>Dog / Cat</u>	Is your pet spayed/neutered?	<u>Y/N</u>	<u>M/F</u>	
Breed: _____	<b>Circle services needed:</b>	Spay/Neuter	Vaccines	Tests	Wellness	None
Pet Name: _____	Age: _____	(Please Circle) <u>Dog / Cat</u>	Is your pet spayed/neutered?	<u>Y/N</u>	<u>M/F</u>	
Breed: _____	<b>Circle services needed:</b>	Spay/Neuter	Vaccines	Tests	Wellness	None
Pet Name: _____	Age: _____	(Please Circle) <u>Dog / Cat</u>	Is your pet spayed/neutered?	<u>Y/N</u>	<u>M/F</u>	
Breed: _____	<b>Circle services needed:</b>	Spay/Neuter	Vaccines	Tests	Wellness	None

**Below are the average costs for the services we provide through our Assistance Program  
The Assistance Program is funded by donors; services are available as funds are available.**

**Prices**

- \$20-50% off surgery for each pet
- \$7-10 exam fee for Wellness Services
- *Extended office visit and/or skin/ear exams are not included in wellness services*
- \$10 for each Rabies, DHPPV or FVRCP vaccine
- \$10 for microchip
- \$6 heartworm test
- \$28 pre-anesthetic bloodwork

Do you have a current Veterinarian: Yes / No If so, who is that Veterinarian? \_\_\_\_\_

Total Household Income: \_\_\_\_\_ WK/MO/ YR # of Adults in Home \_\_\_\_\_ # of children in home: \_\_\_\_\_

What type/s of government assistance do you receive, if any? \_\_\_\_\_

Are any of these on the behalf of your dependents, if so which? \_\_\_\_\_

Please provide a brief description of the reason you are requesting financial assistance: \_\_\_\_\_

**Release and Certification of Information:**

For value received, I/we, the owner(s) of the above-designated cats and/or or dogs, do hereby fully and completely release and discharge H.O.P.E. for Animals and all persons, agents, employees, directors, and officers thereof and/or on its behalf liable from and against any and all actions, causes of action, claims, demands, assertions, contentions, suits, damages, expenses and/or losses of any kind and description which in any manner pertain to, concern, involve or relate to the care and medical treatment of my/our pet(s), including injury or death, and I/we agree to indemnify and hold harmless all entities and persons being released hereunder from and against any and all actions, causes of actions, claims, demands, assertions, contentions, suits, damages, expenses, and losses resulting from the foregoing activities. By my signature below I certify that I understand that H.O.P.E.'s assistance program is for limited income pet owners only, and the information provided is accurate and complete, and that this information is subject to verification prior to approval.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## Qualifying Programs

- Energy Assistance Program
- Food Stamps
- Major VA Disability
- Medicaid (not Medicare)
- Public School Free Lunch Program
- Section 8 Housing
- Social Security Disability (SSD) – (not S-S-Retirement Income)
- Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)
- Supplemental Security Income (SSI)

Household Size	Gross Annual Income	Monthly	Weekly
1	\$22,980	\$1,915	\$479
2	\$31,020	\$2,585	\$647
3	\$39,060	\$3,255	\$814
4	\$47,100	\$3,925	\$981
For each additional person	add \$8,040	\$670	\$168

<b>STAFF USE ONLY:</b>	Approved Y / N	Approving Manager: _____	Date: _____
	Services approved:	Called: _____	By: _____
	S/N      Microchip		
	Wellness    Tests	Pets approved: _____	
Vaccines    Pre-anesthetic bloodwork	Price bracket: Indiana resident / Non-Indiana resident / No income		
<b>NOTES:</b>			