

ASSISTANCE DOG NETWORK

This application gives us some general information that will be used to determine your eligibility. There are three sections to the application: 1) Service Dog Application Form; 2) Medical Background Form; and 3) Personal Reference Form. If you have any questions, please feel free to contact me so we can discuss any questions you have. Please be assured that all information submitted will be kept confidential.

Thank you for your interest in Assistance Dog Network.

Sincerely,

Rox Ann Kight
Director

ASSISTANCE DOG NETWORK

SERVICE DOG APPLICATION

Background:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

County: _____

Daytime Phone Number: () _____ () work () home

Evening Phone Number: () _____ () work () home

Other (fax, pager, etc.): () _____

E-mail address: _____

Employer (if applicable): _____

Work Address: _____

Name of friend or relative if we can't reach you: _____

Relationship: _____

Address: _____

City: _____ State: _____ Zip: _____

Daytime Phone Number: () _____ () work () home

Evening Phone Number: () _____ () work () home

Other (fax, pager, etc.): () _____

E-mail address: _____

How did you learn about Assistance Dog Network? _____

How will a service dog help you? _____

Home/Lifestyle:

Marital status: () Single () Married () Divorced () Separated () Widowed

How many people live with you? _____

<u>Name</u>	<u>Age</u>	<u>Relationship</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you or is anyone living with you allergic to dogs? () Yes () No

If yes, who is allergic and to what extent? _____

Current living arrangement (please check all that apply):

- () Live independently
- () Live with parents
- () Live with attendant
- () Others
- () In a house
- () In an apartment
- () In trailer home
- () In group housing

How do you spend your leisure time? (TV, shop, eat out, visit friends, etc.): _____

If you use attendant(s), who pays his/her wages? _____

Are you currently receiving government benefits? () Yes () No

Are you or will you be compensated through an insurance company? () Yes () No

If yes, please provide the name/address of the insurance company: _____

How do you deal with anger or frustration toward family or friends? _____

How do you deal with anger or frustration towards those serving you (waitress, personal attendant)? _____

How do you deal with anger or frustration towards authority figures? _____

How do you deal with frustration toward objects which hinder you? _____

How would you describe your motivation (self-motivated or motivated by outside stimuli?)

Would you say you are in control of your environment or controlled by it? _____

How would you describe your level of independence in relation to your maximum physical ability? _____

How would you describe your level of independence in relation to your maximum emotional ability? _____

Rate yourself on a scale of 1 to 5 in the following areas:

Rarely		Occasionally		Frequently
1	2	3	4	5

- ___ I am assertive when I face conflicting opinions.
- ___ I am confident when I am faced with unfamiliar circumstances.
- ___ I am able to respond rationally to crises.
- ___ I openly express my feelings of fear, love, sorrow, etc.
- ___ I am willing to accept correction or constructive criticism.
- ___ I am willing to test and learn new concepts if they differ from my previous beliefs.
- ___ I am able to handle responsibilities.
- ___ I am able to express my feelings of anger and frustration appropriately.
- ___ I am an emotionally sensitive individual.
- ___ I am shy around people I do not know.
- ___ I am able to laugh at myself when I make a mistake.
- ___ I try to take other people's feelings into consideration.
- ___ I embarrass easily.
- ___ I cry easily.
- ___ I am an exuberant individual.
- ___ I am a comedian.
- ___ I often have to hide my feelings.
- ___ I like to try new things.
- ___ I have spent time around animals.

Medical:

Date of Birth: ___ / ___ / _____

Approximate Height: _____ Approximate Weight: _____

Describe your disability: _____

Number of years disabled: _____ Cause of disability: _____

If disability was caused by injury, what progress has been made post injury? _____

Scale 1 to 5 (5 being greatest)

Physical challenges:

- Physical strength
- Endurance
- Balance
- Speech difficulty

- Pain
- Mobility
- Vision difficulty
- Other: _____

Do you use a wheelchair? Yes, manual Yes, power No
Describe any other specialized equipment you use (cane, walker, van lift, etc.)

List any additional health (physical or mental) issues (diabetes, epilepsy, etc.):

List any/all medications you are currently taking, dosage and purpose:

<u>Name</u>	<u>Dosage</u>	<u>Purpose</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Pet History:

Have you ever had a dog? Yes No
Do you have a dog now? Yes No
If yes, what kind and how old is the dog(s)? _____
How do they react to other dogs/animals? _____

Please list other pets living in your home: _____

Please list the name and address of your veterinarian:

Dr: _____ Phone: _____
Hospital: _____
Address: _____
City: _____ State: _____ Zip: _____

Are we free to contact your vet for a referral on your behalf? Yes No.

Living with a Service Dog:

A service dog needs daily training, attention, love and care. Do you commit to the following?

- Yes No Follow the trainer's instructions on feeding schedule, recommended diet, housebreaking, bathing and weekly grooming.

- Yes No Keep the dog in good health. That means taking it to the veterinarian when necessary, giving the dog heartworm preventative medication, treating the dog, your home and yard for flea in flea season, emergency care and anything else necessary for the good health of the dog.
- Yes No Prepare for and participate in a one hour session in your home with the trainer, two times each week.
- Yes No Practice training with the dog (homework) 15 minutes every day.
- Yes No Treat the dog as a working dog, not just a pet. That means not allowing strangers to pet the dog in public without your permission, making the dog behave in public and being the only person in your family responsible for the dog's care.
- Yes No Telling the trainer if you or the dog are having any problems with training, obedience or any other questions.

Will the dog travel with you? Always Sometimes Never

Do you plan to take the dog to work or school? Yes No

Where will the service dog stay if you are hospitalized? _____

Do you have an enclosed yard? Yes No.

What traits do you like in a dog (e.g. size, color, personality, abilities)? _____

What traits do you dislike in a dog? _____

Are you willing to adapt your attitude/lifestyle to meet your dog's physical and psychological needs (e.g. a service dog lives indoors full-time)? Yes No.

Are you prepared for the responsibility of adopting another member into your family for the next 7 to 10 years? Yes No.

Are the individuals in your family with whom you are live, willing and prepared to allow you full charge of the service dog? Yes No.

I have read the above information and understand the commitment of time, money and love involved in owning a service from Assistance Dog Network.

Applicant Signature: _____ Date: _____

Parent's Signature: _____ Date: _____
(if under 18 years of age)



PERSONAL REFERENCE FORM

I authorize the release to Assistance Dog Network, the following information regarding my condition. This information will not be used for any purpose other than to evaluate my application for a service dog to assist me in daily living. This information will be kept confidential.

Applicant Signature: _____ Date: _____

Parent's Signature: _____ Date: _____
(if under 18 years of age)

Name of applicant: _____

Form completed by: _____

Title: _____ Agency: _____

Address: _____

City: _____ State: _____ Zip: _____

Daytime Phone Number: () _____ () work () home

Evening Phone Number: () _____ () work () home

Other (fax, pager, etc.): () _____

E-mail address: _____

Length of association with applicant: _____

In what capacity: _____

Describe applicant's impairment: _____

Cause of impairment: _____

Prognosis and effect of impairments on applicant's ability to perform daily activities (feeding, dressing, personal care, etc.): _____

Describe the applicant's progress in performing daily activities: _____

Describe areas where you think the applicant needs improvement: (improving mood/outlook, completing projects, reducing dependence on medications, etc.): _____

List any/all medications the applicant is currently taking, dosage and purpose:

<u>Name</u>	<u>Dosage</u>	<u>Purpose</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Is the applicant:

- () Yes () No In charge of his/her own environment (e.g. manages own finances, instructs attendants).
- () Yes () No Capable of practicing at least 30 minutes a day and participating in periodic training sessions.
- () Yes () No Mature and self-motivated to maintain the training schedule.
- () Yes () No Able to exercise judgment and make decisions necessary for daily activities.
- () Yes () No Able to sustain attention span.
- () Yes () No Able to control physical or motor movement sufficient to sustain daily activities.
- () Yes () No Short term memory intact and functioning.
- () Yes () No Able to follow directions and learn to the degree necessary for daily activities.
- () Yes () No Capable of decisions regarding personal and others' safety.

- | | | |
|------------------------------|-----------------------------|---|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Under medication which impairs functioning. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Under medication which impairs short-term memory. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Able to control anger and manage frustration. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Is incapacity due to or affected by alcohol or drug abuse.
If so, please complete the following: |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Has applicant been accepted in a treatment facility. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Is applicant capable of rational decisions. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Is applicant a danger to self or others. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Has applicant refused treatment. |

Additional remarks: _____

Signature: _____ Date: _____

Please send completed application to:

**Assistance Dog Network
 54514 Rosa Road
 Bandon, Oregon 97411
 (541-347-5414)**



MEDICAL BACKGROUND FORM

I authorize the release to Assistance Dog Network, the following information regarding my condition. This information will not be used for any purpose other than to evaluate my application for a service dog to assist me in daily living. This information will be kept confidential.

Applicant Signature: _____ Date: _____

Parent's Signature: _____ Date: _____
(if under 18 years of age)

Name of applicant: _____

Form completed by: _____

Title/profession: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: () _____

Other (fax, pager, etc.): () _____

E-mail address: _____

Length of association with applicant: _____

Date of last exam: _____

Describe applicant's impairment: _____

Cause of impairment: _____

Prognosis and effect of impairments on applicant's ability to perform daily activities (feeding, dressing, personal care, etc.): _____

Describe the applicant's progress in performing daily activities: _____

Describe areas where you think the applicant needs improvement: (improving mood/outlook, completing projects, reducing dependence on medications, etc.): _____

List any/all medications the applicant is currently taking, dosage and purpose:

<u>Name</u>	<u>Dosage</u>	<u>Purpose</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

A service dog needs daily training and attention, love and care, periodic veterinary examinations, flea and heartworm medications, bathing, good nutrition and emergency care. Please answer the following:

- Yes No Applicant is in charge of his/her own environment (e.g. manages own finances, instructs attendants).
- Yes No Applicant is capable of practicing at least 30 minutes a day and participating in periodic training sessions.
- Yes No Applicant has the maturity and self-motivation to maintain a training schedule.

Is the applicant:

- Yes No Able to exercise judgment and make decisions necessary for daily activities.
- Yes No Able to sustain attention span.
- Yes No Able to control physical or motor movement sufficient to sustain daily activities.
- Yes No Short term memory intact and functioning.

- Yes No Able to follow directions and learn to the degree necessary for daily activities.
- Yes No Capable of decisions regarding personal and others' safety.
- Yes No Under medication which impairs functioning.
- Yes No Under medication which impairs short-term memory.
- Yes No Able to control anger and manage frustration.
- Yes No Is incapacity due to or affected by alcohol or drug abuse.
If so, please complete the following:
- Yes No Has applicant been accepted in a treatment facility.
- Yes No Is applicant capable of rational decisions.
- Yes No Is applicant a danger to self or others.
- Yes No Has applicant refused treatment.

In what ways do you feel this individual might benefit from a service dog: _____

Can you recommend that this individual receive a service dog: Yes No
 If yes, in what areas: _____

Are you personally familiar with service dogs: Yes No
 Do you have any patients with any type of assistance dog (hearing dog, service dog, guide dog for the blind): Yes No

May we contact you with questions: Yes No

Additional remarks: _____

Signature: _____ Date: _____

**Please send completed application to:
 Assistance Dog Network
 54514 Rosa Road
 Bandon, Oregon 97411
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