



## **HSSBV Canine Medical Assistance Conditions**

Dear Applicant,

Thank you for your inquiry into the Medical Assistance Program for LOW INCOME DOG OWNERS. Attached is the application. In order for the Humane Society of San Bernardino Valley to expedite your request for veterinary care on behalf of your pet, please fill out this application **legibly, completely** and **return** it to the HSSBV. Make sure that you include all necessary documents listed below. The HSSBV will then make every attempt to process your application for approval.

**Turning in your application does not guarantee assistance.**

Only those individuals providing verification of the following requirements will be eligible for assistance:

- **Valid photo Identification**
- **Proof of ownership of the dog if this is your first time at our clinic with your dog (city license, vet records, etc)**
- **Proof of one of the following (must be dated within the last three months):**
  - **Unemployment benefits**
  - **SSI disability benefits**
  - **Social Security benefits**
  - **Non-commissioned active military**
  - **WIC recipient (WIC debit card is not proper documentation)**
  - **Low income client with the following documentation**
    - **First page of income tax return shows client lives at or below the poverty line or qualifies for WIC benefits.**

**Please turn in the estimate for the procedure for the dog you are requesting assistance with, along with your other supporting documents.**

The Medical Assistance program has limited financial aid available and is not meant as a resource to manage the continuing care of a pet. The intent of the grant is to assist as many pet parents and their dogs within each funding period. You will most likely receive **partial payment assistance** with your request. The program is limited to the care of two pets per application. If you have any questions regarding this program please contact our office.

Respectfully,

The Humane Society of San Bernardino Valley  
374 W. Orange Show Road  
San Bernardino, CA 92408  
(909) 386-1400



## CANINE MEDICAL ASSISTANCE GRANT APPLICATION

Client Name: \_\_\_\_\_ Acct #: \_\_\_\_\_

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

Telephone: (    ) \_\_\_\_ - \_\_\_\_\_

Number of people in household: \_\_\_\_\_ Current monthly income: \$ \_\_\_\_\_

Estimated amount you are able to contribute to care: \$ \_\_\_\_\_

I understand filling out this application does not guarantee financial assistance. I also understand if I do not supply the requested documents, my application will not be processed.

I understand APPLICATION AND MATERIALS MUST BE TURNED IN BEFORE MY SCHEDULED APPOINTMENT. "Day of" assistance will not be available unless arranged in advance with a staff member by appointment.

I also understand I am responsible for paying the balance after assistance on the date of service.

Client signature \_\_\_\_\_

Sources of income:

- Social Security
- SSI
- Pension
- Employment
- Other: \_\_\_\_\_

List your total number of dogs you are asking for assistance for:

Dogs: \_\_\_\_\_

### Which pets(s) currently need veterinary care?

Pet #1

Breed of pet: \_\_\_\_\_

Name of pet: \_\_\_\_\_

Pet #2

Breed of pet: \_\_\_\_\_

Name of pet: \_\_\_\_\_

Sex of pet(s): 1<sup>st</sup> pet:  Male  Female

2<sup>nd</sup> pet:  Male  Female

Age of pet: \_\_\_\_\_

Age of pet: \_\_\_\_\_



**Type of Service Requested:**

- \_\_\_\_\_ Dental Care.....Estimated Cost: \$ \_\_\_\_\_
- \_\_\_\_\_ Medical care by veterinarian.....Estimated Cost: \$ \_\_\_\_\_
- \_\_\_\_\_ Emergency care.....Estimated Cost: \$ \_\_\_\_\_
- \_\_\_\_\_ Lab work/ Diagnostic testing.....Estimated Cost: \$ \_\_\_\_\_
- \_\_\_\_\_ Unusual medical procedures/medications.....Estimated Cost: \$ \_\_\_\_\_
- \_\_\_\_\_ Client Contribution.....: \$ \_\_\_\_\_

The information provided above is true and accurate. I understand that funding is limited and I may not receive assistance, even if I qualify, if there is no more funding for the current fiscal year. Final approval is at the discretion of the Humane Society of San Bernardino Valley.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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**For Staff Use Only**

**Application Check List- Photo copy:**

**Required:**

- Valid CA Drivers License (all applicants)

**ONE of the following required, dated within the last THREE MONTHS:**

- First page of most recent taxes to prove income and household size
- Unemployment Verification
- SSI Disability Verification
- Social Security Verification
- Non-commissioned Active Military
- WIC Verification (WIC debit card not accepted)
- Proof income meets WIC recipient guidelines or state low income guidelines
- Emergency

**Proof of Pet Ownership:**

- Dog License
- Past Medical Records
- Other (specify): \_\_\_\_\_

Completed by Name: \_\_\_\_\_ Title: \_\_\_\_\_