



Administration
8446 South Florida Avenue, Floral City, FL 34436-3115
352-560-3785

www.HeroAssistanceDogs.org

ASSISTANCEDOGAPPLICATION

PartOne

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

APPLICATION INFORMATION:

Be certain to include all of the following materials in your application packet:

- ➤ Completed application part one and two
- ➤ Recent close up photograph of yourself
- ➤ Autobiography (please use separate sheet)
- ➤ Map to your home from the nearest main highway. (A copy of a page from a map book is acceptable.)

If any of the above items are not included in your packet, Heroes will not be able to process your application. Please make certain that all the required documents are filled out completely, leaving no blanks. Use a separate paper if needed. A home visit is part of the application process.

Placement:

Once the application process is completed, you will be notified of your status. If accepted, you will be placed on a waiting list until a potential match is available. The amount of time for this match may vary depending on availability of dogs and your particular needs. Once a potential match has been identified, you, the applicant, will be expected to participate in team training and pass a public access test before receiving the service dog.

Please send all applications to:

Hero Assistance Dogs, Inc.
8446 South Florida Avenue
Floral City, FL 34436

FOR OFFICE USE ONLY

DATE RECEIVED ____/____/____ RECEIVED BY: _____

ITEMS MISSING: _____

PERSONAL INFORMATION

Name: _____

Address: _____

City: _____ State: _____ Zip: _____ County: _____

Birth Date: ____/____/____ Phone: (____) _____ Cell (____) _____

Place of Employment: _____

Work Address: _____ Work Phone: (____) _____

Cell Phone: (____) _____ Email Address: _____

City: _____ State: _____ Zip: _____

Nearest Relative: _____ Relationship: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: (____) _____

How did you hear about Hero Assistance Dogs, Inc.?

What is your disability? _____

How long have you been disabled? _____

Please circle the correct answer:

Married Single Divorced Separated Widowed

I live in a: House Apartment Other: _____

I live with: Parents Spouse Group / Number of residents in home: ____ Alone

My home has a: Fenced yard Enclosed Area

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

Children: # _____ Ages: _____

Do you currently receive government benefits? Yes No SSI: \$ _____ SSDI: \$ _____

Other: \$ _____ Monthly income (other than gov. 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

Please describe work/school environment: _____

2) Describe your activity level (low, moderate, high) and explain: _____

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

4) Please, describe your house and yard: _____

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

6) Please, describe all means of transportation that you use: _____

7) Are you able to travel and deal with the time and expense away from home for two weeks of Team Training? _____

8) What kinds of adaptive equipment do you routinely use?

9) Please, describe the animals currently living in your home:

10) Please, describe your knowledge of dog care:

11) Please, describe your knowledge of dog behavior:

12) 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?

13) What characteristics do you like in a dog?

14) What characteristics do you dislike in a dog?

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

Please rate yourself in the following area. Number 1 represents the lowest rating, 3 represents average, and 5 represents the highest. Circle the number which best defines you:

1) Assertive ability with other people when facing differences of opinion: 1 2 3 4 5

2) Self-confidence when facing new or uncertain circumstances or problems: 1 2 3 4 5

3) Ability to react calmly to crisis: 1 2 3 4 5

4) Expression of fear: 1 2 3 4 5

5) Expression of sorrow: 1 2 3 4 5

6) Expression of love: 1 2 3 4 5

7) Expression of hope: 1 2 3 4 5

8) Expression of anger: 1 2 3 4 5

9) Expression of joy: 1 2 3 4 5

10) Ability, when challenged, to stand your ground: 1 2 3 4 5

11) Willingness to learn new concepts, even if contrary to current beliefs: 1 2 3 4 5

12) Ability to carry and assume responsibility: 1 2 3 4 5

13) Ability to control emotions: 1 2 3 4 5

14) Emotional sensitivity: 1 2 3 4 5

15) Willingness to accept criticism: 1 2 3 4 5

16) Ability to laugh at yourself 1 2 3 4 5

17) Sensitivity to embarrassment: 1 2 3 4 5

18) Personal shyness: 1 2 3 4 5

19) Ability to empathize: 1 2 3 4 5

20) Personal exuberance: 1 2 3 4 5

21) Please, give any further information about yourself that might be helpful in making an assessment:

22) We ask that you contact your local service clubs (Elks, Lions, Rotary, etc.) for possible sponsorships. Are you willing to do this? _____

HERO ASSISTANCE DOGS, INC. ANTI-DISCRIMINATION CLAUSE

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

ASSISTANCE DOG APPLICATION - PART 2

APPLICANT MEDICAL HISTORY RELEASE FORM

Print Name: _____

I authorize the release of any requested information regarding my health to Hero Assistance Dogs, 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. Heroes 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: _____

ASSISTANCE DOG APPLICATION - Part 2 continued

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 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

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

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

If yes, what?

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

Yes No Minimally

If 5 is 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? _____

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

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:

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 interval since last seizure:

8. Learning Disabilities: Yes No

If yes, please describe:

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 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:

Team 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 Team 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 Team Training:

PHYSICIAN'S STATEMENT:

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

Physician's Signature

Date