ASSISTANCE/SERVICE DOG APPLICATION

Part One

APPLICATION INFORMATION

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

- ☐ Completed application part one and two
- ☐ Recent photograph of yourself
- ☐ Autobiography (please use separate sheet)
- ☐ $50.00 application donation (non-refundable)

If any of the above items are not included in your packet, CST will not be able to process your application. Please remember to make certain that all the required documents are received by CST.

COST: (CST DOGS ONLY)

Application: Include a $50 non-refundable Application fee with your completed application.

Placement: Once a potential match has been identified, the applicant will be expected to contribute towards a portion of the cost of preparing the service dog during the two years it is in the training program. The placement fee is $6,500.00 and is to be paid in full before the 1st day of Team Training. THIS FEE IS NON-REFUNDABLE
Int.______________

You will be required to travel to CST for 12 days of Team Training (travel, lodging, meals, & activities are at your expense) and for your yearly re-certification, which the cost is $100.00 a year. Int._________________

Please send all applications to: **Canine Support Teams, Inc.**
P.O. Box 891767
Temecula, CA 92589-1767

FOR OFFICE USE ONLY

DATE RECEIVED _____/_____/_____ **RECEIVED BY:** _________________________

ITEMS MISSING: ____

Canine Support Teams
P.O. Box 891767
Temecula CA 92589-1767
Phone: (951) 301-3625 ● Fax: (951) 301-3605
cstmain@aol.com
www.caninesupportteams.org

ASSISTANCE DOG APPLICATION

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 Canine Support Teams? _________________________________

____

What is your disability? ____

____

How long have you been disabled? ____

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PERSONAL INFORMATION (Check all that apply)

Print Name: ____

☐ Married ☐ Single ☐ Children: #_______ Ages: ________________

☐ Divorced ☐ Separated ☐ Widowed

I live in a: ☐ House ☐ Apartment ☐ Other: __________________

I live with: ☐ Parents ☐ Spouse ☐ Group

☐ Alone ☐ Number of residents in home: _______________

My home has a: ☐ Fenced yard ☐ Enclosed Area

My other pets include: ☐ Dogs # _____ ☐ Cats #_____ ☐ Birds #______

Breeds & Gender ____

You must be able to travel to CST. Can you? ☐ Yes ☐ No

If no, please give a reason: ____

Do you currently receive government benefits? ☐ Yes ☐ No

☐ SSI: $_____________ ☐ SSDI: $_____________ ☐ Other: $ ________________

Monthly income (other than government benefits) $________________

Do you ☐ Rent or ☐ Own your home? Amount of Rent/Mortgage per month $_______

1) Check 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: ___________________________________

____

____

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PERSONAL INFORMATION (Continued)

Print Name: ____

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?

____

____

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PERSONAL INFORMATION (Continued)

Print Name: ____

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:

____

____

____

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PERSONAL INFORMATION (Continued)

Print Name: ____

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

CANINE SUPPORT TEAMS, INC. ANTI-DISCRIMINATION CLAUSE

It is the policy of CST 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.

CST 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**

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ASSISTANCE DOG APPLICATION
PART TWO

APPLICANT MEDICAL HISTORY RELEASE FORM

Print Name: ____

I authorize the release of any requested information regarding my health to Canine Support Teams. 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. CST 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: _________________________

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ASSISTANCE DOG APPLICATION
Part two

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 client'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 Client:

1. Does your client have the ability to exercise judgment and make decisions necessary for ADL? ☐ Yes ☐ No
2. Does your client possess the ability of memory and perception necessary for ADL? ☐ Yes ☐ No ☐ Minimally
3. Does your client have the ability to sustain a reasonable attention span?

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

   ☐ Yes ☐ No

   If yes, what?

   ____
   ____
   ____
   ____

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5. Does your client demonstrate inappropriate behavior that is beyond his/her control? ☐ Yes ☐ No ☐ Minimally

   If yes, please explain:

   ____

   ____

   ____

6. Does your client possess the ability to learn and follow directions to the degree necessary to sustain ADL? ☐ Yes ☐ No ☐ Minimally

7. Is your client able to make decisions concerning his/herself as well as others needs and safety? ☐ Yes ☐ No ☐ Minimally

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

   ☐ Yes ☐ No

   If yes, please complete the following:

   a) Has your client ever been accepted into a treatment facility?

      ☐ Yes ☐ No

      If yes, when: ____

   b) Has your client ever refused treatment or a referral to a treatment center?

      ☐ Yes ☐ No

   c) Is your client capable of making rational decisions?

      ☐ Yes ☐ No

   d) Does your client present a danger to him/herself or others?

      ☐ Yes ☐ No

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

   ☐ Yes ☐ No

10. May we contact you for more information or clarification?

   ☐ Yes ☐ No

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Providers of Assistance Dogs

11. Additional Comments:

____
____
____
____
____
____
____
____
____
____
____
____

___________________________________ ___________________

Signature of Professional Date

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MEDICAL HISTORY REPORT

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:

   ____
   ____
   ____

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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 integral 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 above, please explain.

   ____
   ____

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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 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:

____

____

____

____

<u>Restrictions and Recommendations for Patient during Team Training:</u>

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:

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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.

______________________________________ ________________

Physician's Signature Date

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