



Print Name: _____

ASSISTANCE/ASSISTANCE DOG APPLICATION Part One APPLICATION INFORMATION

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

- Completed application part one and two
- Recent photograph of yourself
- Autobiography (please use separate sheet)
- Attach Financial Documentation
- \$50.00 application donation (non-refundable, *waived for veterans*)
- Initial below regarding Fee for Dog.
- Copy of DD214 (for Veterans Only)

If any of the above items that are missing from your packet will cause delay in processing your application. Please make certain that all the required documents are submitted to CST.

COST: (CST DOGS ONLY)

Application: Include a \$50 non-refundable Application Fee* with your completed application.

**Application Fee is waived for veterans.*

Placement: Once a potential match has been identified, the applicant will be expected to contribute towards a portion of the cost of preparing the Assistance Dog during the two years it is in the training program. The placement fee is \$6,500.00. CST will assist if needed by creating a campaign on our website to complete this requirement prior to the 1st day of Team Training. Applicants and graduates are not required to participate in fundraising or public relations activities without expressed and voluntary permission. No person will be denied the opportunity to be considered as an applicant because of limited financial ability.

THIS FEE IS NON-REFUNDABLE Funds raised through a campaign on our website will be used for other clients if we cannot fulfill your needs. **Int.** _____

**Placement Fee is waived for veterans.*

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 (*waived for veterans). **Int.** _____

Please send completed application to: **Canine Support Teams, Inc.**
P.O. Box 75
Murrieta, CA 92564

After receiving your application, we will contact you within two weeks to confirm receipt of your information and to schedule an interview. If you do not hear from us within the two-week period, please email us: cstmain@caninesupportteams.org.

FOR OFFICE USE ONLY: **DATE RECEIVED** ____ / ____ / ____ **RECEIVED BY:** _____

ITEMS MISSING: _____



Print Name: _____

ASSISTANCE DOG APPLICATION

PERSONAL INFORMATION

Name:					
Address:					
City:		State:		Zip:	
Birth Date: / /		(Clients under the age of 18 are considered on a case-by-case basis)			
Ethnicity: (Optional)					
Gender do you identify as: (Optional)					
Email:					
Home Phone:		Mobile:			
Place of Employment:					
Work Phone:					
Work Address:					
City:		State:		Zip:	

Nearest Relative:		Relationship:			
Address:					
City:		State:		Zip:	

CST ensures that your key “care professionals” are aware of their application and the implications for their on-going care. Care professionals can include a teacher in your school, physical therapist, personal care assistant, etc., depending on your circumstances.

Care Professional:		Relationship:			
Address:					
City:		State:		Zip:	

Care Professional:		Relationship:			
Address:					
City:		State:		Zip:	



Print Name: _____

How did you hear about Canine Support Teams?
What is your disability?
How long have you been disabled?



Print Name: _____

PERSONAL INFORMATION (Check all that apply)

INCOME

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

Monthly income (other than government benefits) \$ _____

Do you Rent or Own your home? Amount of monthly Rent/Mortgage \$ _____

REQUIRED FINANCIAL DOCUMENTATION (To be attached to this application)

- Please call the automated IRS Transcript order line at 800-908-9946 and order the short form request for Individual Tax Return (4506T) for the last tax year. The IRS will mail your transcript in 5-10 days. There is no cost to order this document. or
- If you did not file a federal tax return you must provide proof of income. or
- If you have no income, please tell us who is supporting you and who will provide financial responsibility for the dog's care and welfare.

Check all that apply:

Work at home Work outside home Attend school Unemployed Retired

Please describe work/school environment: _____

Married Single Children: # _____ Ages: _____

Divorced Separated Widowed

I live in a: House Apartment Other:

I live with: Parents Spouse Group Home

Alone Room-mate(s) Number of residents in home: _____

My home has a: Fenced yard Enclosed Area



Print Name: _____

PERSONAL INFORMATION (Continued)

My pets include: Dogs # _____ Cats # _____ Birds # _____

Age, Breeds, Gender

Are they spayed/neutered?

Please describe your house and yard:

You must be able to travel to CST, are you able to travel and deal with the time and expense away from home for two weeks of Team Training? Yes No

If no, please give a reason: _____

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

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



Print Name: _____

PERSONAL INFORMATION (Continued)

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

Please describe all means of transportation that you use:

What kinds of adaptive equipment do you routinely use?

Please describe your knowledge of dog care:

Please describe your knowledge of dog behavior:



Print Name: _____

PERSONAL INFORMATION (Continued)

Print Name: _____

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?

What characteristics do you like in a dog?

What characteristics do you dislike in a dog?

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



Print Name: _____

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: | | | | | |



Print Name: _____

PERSONAL INFORMATION (Continued)

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, marital status, age, or physical or mental disabilities or medical conditions.

It is the policy of CST for its staff and volunteers to always treat all persons with respect and dignity.

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**



Print Name: _____

**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 except 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: _____



Print Name: _____

**ASSISTANCE DOG APPLICATION
Part two**

Professional Reference Report

THIS SECTION 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, managing finances, maintaining home and attaining needed outside services.

Patient suffers from or is being treated for the following:

- | | | |
|---|--|---|
| <input type="checkbox"/> Traumatic Brain Injury (TBI) | <input type="checkbox"/> Post-traumatic Stress Disorder (PTSD) | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Anxiety and/or Depression | <input type="checkbox"/> Spinal Cord or Disc Injury | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Disequilibrium or Balance Issues | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> Post-polio Syndrome | <input type="checkbox"/> Cerebral Palsy |
| <input type="checkbox"/> Bi-polar Disorder | <input type="checkbox"/> Loss of limb | |

Other:



Print Name: _____

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 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



Print Name: _____

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

Yes No

If yes, please complete the following:

1. 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 patient for an assistance dog?

Yes No

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

Yes No

11. Additional Comments:

Signature of Professional

Date



Print Name: _____

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

Right: _____ Left: _____

If yes, please describe:

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 patient requires dialysis, type of dialysis, and frequency:



Print Name: _____

Use of Catheter Yes No
If yes is it Suprapubic or Indwelling

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:



Print Name: _____

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.

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:



Print Name: _____

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 outings involve typical ADL and 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 greatly reduces 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.

Physician's Signature

Date