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
- ☐ $100.00* Non-refundable application fee
- ☐ Initial below regarding Fee for Dog.
- ☐ Veterans Only-Copy of DD214 & letter from LCSW verifying diagnosis of PTSD/TBI/MST

COST

Application: Include a $100 non-refundable Application Fee* with your completed application.

Placement: Applicants are expected to contribute towards a portion of the cost of the Service Dog. Fees are due prior to the 1st day of Team Training. **Int._____**

- ☐ CST Service Dog Fee: $9,500*
- ☐ Successor Service Dog Fee $7,500*
- ☐ Outside Certification Training Fee: $5,500*

If needed, CST will create a campaign on our website to complete this requirement.
FEES ARE NON-REFUNDABLE Funds raised through a campaign on our website will be used for other clients if we cannot fulfill your needs. **Int._____**

Re-Certification Fee: $100*/Annually **Int._____**

You will be required to travel to CST for 12 days of Team Training
(Travel, lodging, meals, & activities are at your expense) **Int._____**

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.

Fees waived for veterans.

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

We will contact you within two weeks to confirm receipt of your application packet to schedule an interview. If you do not hear from us within the two-week period, please contact us.

FOR OFFICE USE ONLY: **DATE RECEIVED_____/______/______** **RECEIVED BY: ______**
ITEMS MISSING:________________________________

Canine Support Teams, Inc.
PO Box 75, Murrieta, CA 92564
951-301-3625
cstmain@caninesupportteams.org www.caninesupportteams.org

Print Name: ______________________________________

ASSISTANCE DOG APPLICATION

PERSONAL INFORMATION

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

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

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

Name:		Relationship:			
Address:					
City:		State:		Zip:	

Name:		Relationship:			
Address:					
City:		State:		Zip:	

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Print Name: ______________________________________

How did you hear about Canine Support Teams?
What is your disability?
How long have you been disabled?
Is your disability service-related or service connected?

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

Name:		Relationship:			
Address:					
City:		State:		Zip:	

Name:		Relationship:			
Address:					
City:		State:		Zip:	

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Print Name: ____

PERSONAL INFORMATION (Check all that apply)

INCOME

Do you currently receive government benefits? ☐ Yes ☐ No

☐ SSI: $_____________ ☐ SSDI: $______________ ☐ VA Benefits: $________________

Annual 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 ☐ Roommate(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:

____

____

____

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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:

____
____
____

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?

____

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Print Name: ______________________________________

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?

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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:

____

____

____

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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**

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cstmain@caninesupportteams.com www.caninesupportteams.org

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: ____________________

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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:

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

Other:
____
____
____
____

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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

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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

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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:

____

____

____

____

____

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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:

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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:

____

____

____

____

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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

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