

Assistance Dog United Campaign

April 1, 2023

Dear prospective voucher recipients,

Assistance Dog United Campaign accepts applications for vouchers during the months of April and May. The recipients of a voucher will be able to use it towards the payment of an assistance dog from one of our provider programs. In each of the last three years, we have received well over 100 applications during the open application period.

Unfortunately, Assistance Dog United Campaign (ADUC) has limited funds to work with. We know the application takes considerable time for you to fill out and want to make you aware that we will only be able to grant 3-5 vouchers this year. Please take that into consideration before starting the application process.

Please white out any social security information on your financial information before sending.

Due to the fact that ADUC does not have paid office staff, and is run by volunteers, **we will only notify the recipients of vouchers by letter and/or email.** We will not notify applicants who are not awarded a voucher. The only form of communication is via email ~ info@assistancedogunitedcampaign.org. Unfortunately, we cannot respond to other forms of communication.

Sincerely,

Assistance Dog United Campaign



Assistance Dog United Campaign
 10201 Old Redwood Hwy, Penngrove, CA 94951
 Email: info@assistancedogunitedcampaign.org

2023 Application for Assistance Dog Voucher

Please Note: Application must be completed by the applicant or answered under the direction of the applicant. Vouchers are valid for one year from date of issue until July 31, 2024, and may only be used to obtain an assistance dog during that voucher period.

ONLY COMPLETED APPLICATIONS POSTMARKED OR RECEIVED BY 5/31/23 WILL BE CONSIDERED.

Part 1: Contact Information				
Last Name		First Name		Middle Name
Street Address		City	County	State Zip
Mailing Address		City	County	State Zip
Home Phone	Cell Phone	Fax	E-mail	
()	()	()		
Place of Employment			Street/Mailing Address	
City	County	State	Zip	Phone
				()
Emergency Contact		Relationship		Address
City	State	Zip	Home/Work/Cell Phone	
			()	
Part 2: Personal Information				
Date of Birth (Month/Day/Year)		Age	Gender	
/ /				
Marital Status				
<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Long-term Relationship <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Other _____				
Pets in Household				
<input type="checkbox"/> Yes <input type="checkbox"/> No Type _____ Number ___ / Type _____ Number ___ / Type _____ Number ___				

Part 3: Medical Information

Primary Medical Diagnosis/Disability-Cause (If Known) /Age of Onset

Secondary Disability/Medical Conditions

IS THIS DISABILITY PROGRESSIVE? Yes No

Circle The Number That Best Describes Your Medical Condition
0=Non-Applicable 1=Mild 2=Moderate 3=Severe

Motor Impairments

Weakness	0	1	2	3	Coordination	0	1	2	3
Spasticity	0	1	2	3					
Other _____						0	1	2	3

Sensory Impairments

Vision	0	1	2	3	Hearing	0	1	2	3
Loss of Sensation	0	1	2	3					

Cognitive Impairments

Memory	0	1	2	3	Problem-solving	0	1	2	3
Judgment	0	1	2	3	Attention	0	1	2	3

Communication Impairments

Expressive	0	1	2	3	Receptive	0	1	2	3
Written	0	1	2	3					

Psychological/Behavioral Descriptions

Depression	0	1	2	3	Impulsive	0	1	2	3
Difficulty Managing Stress	0	1	2	3	Inappropriate	0	1	2	3
Other _____						0	1	2	3

Additional Medical Conditions

Cardiovascular Disease	0	1	2	3					
Diabetes	0	1	2	3					
Respiratory Disease	0	1	2	3					
Chronic Pain	0	1	2	3					
Neurogenic Bladder	0	1	2	3					
Seizure Disorder	0	1	2	3					
Neurogenic Bowel	0	1	2	3					
Other _____						0	1	2	3

Assistive Devices (Check Any That Apply)

Manual Wheelchair	0	1	2	3	Scooter	0	1	2	3
Power Wheelchair	0	1	2	3	Walker	0	1	2	3
Crutches	0	1	2	3	Cane	0	1	2	3
Orthotics (Braces)	0	1	2	3	Prosthesis	0	1	2	3
Hearing Aid	0	1	2	3					

Please indicate any special instructions/considerations related to your disability/medical condition if (for example, hyperflexia management, seizure precaution, etc.) or any other information that you feel would be pertinent.

Part 4: Activities Of Daily Living

Please identify Functional Independence Measure (FIM) levels for the following motor activities based on this scale:

No Helper

- 7 Complete Independence (Timely, Safely)
- 6 Modified Independence (Device)

Helper-Modified Independence

- 5 Supervision
- 4 Minimal Assistance (You Can Perform 75% of Activity)
- 3 Moderate Assistance (You Can Perform 50% of Activity)

Helper-Complete Dependence

- 2 Maximal Assistance (You Can Perform 25% of Activity)
- 1 Total Assistance (You Can Perform 0% of Activity)

Self-care

Eating	1	2	3	4	5	6	7
Grooming	1	2	3	4	5	6	7
Bathing	1	2	3	4	5	6	7
Dressing-Upper Body	1	2	3	4	5	6	7
Dressing-Lower Body	1	2	3	4	5	6	7
Toileting	1	2	3	4	5	6	7

Sphincter Control

Bladder Management	1	2	3	4	5	6	7
Bowel Management	1	2	3	4	5	6	7

Transfers

Chair/Wheelchair	1	2	3	4	5	6	7
Toilet	1	2	3	4	5	6	7
Tub/Shower	1	2	3	4	5	6	7

Locomotion

Walk	1	2	3	4	5	6	7
Wheelchair	1	2	3	4	5	6	7
Combination of Above	1	2	3	4	5	6	7
Stairs	1	2	3	4	5	6	7

How many hours of attendant care do you receive each week?

Part 5: Confirmation Of Need

What type of assistance dog are you looking for?

Service Guide Hearing Social/Therapy Seizure/Alert/Response Other _____

5. ATTACH A ONE-PAGE DESCRIPTION EXPLAINING HOW AN ASSISTANCE DOG WILL BENEFIT YOU.

Part 6: Financial Information

Are you having financial difficulties obtaining an assistance dog? Yes No If yes, please complete and submit the Personal Declaration form. Be sure to include copies of any paperwork that verifies additional income information to support your need for ADUC financial support, including:

2021 or 2022 IRS tax form with Schedule A Proof of federal assistance Other _____

WHITE OUT YOUR SOCIAL SECURITY NUMBER PLEASE
Applications without this information will not be processed.

Part 7: Signatures

The information on this application is true and correct to the best of my knowledge.

Applicant Signature

Date

If the applicant is a minor, or under guardianship or conservatorship or the ward of the court, the parent or duly authorized representative is required to sign below pursuant to state and federal law.

Name _____ Relationship _____

Mailing Address _____

City _____ State _____ Zip _____ Phone ____ (____) _____

Parent or Guardian Signature

Date

For Office Use Only

Approved Denied Reasons _____

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www.assistancedogunitedcampaign.org

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PERSONAL DECLARATION

This form must be completed by the applicant or answered under the direction of the applicant. You must use the correct legal name for each member of your household. The Voucher Applicant must sign certifying all information provided is true and accurate. All other adult members of the household must sign below certifying information pertaining to them.

Voucher Applicant: _____ Home Phone _____

Current Address _____ City, State _____ Zip Code _____

I. HOUSEHOLD COMPOSITION. List all **adults (18 years or older)** living in the assisted household (including any live-in aide). **List the Voucher Applicant first.** Attach additional sheets if necessary.

Name	Relation to Applicant	Disabled?	Date of Birth	Signature	Have Income	Full time Student
	Voucher Applicant	[] Yes [] No			[] Yes [] No	[] Yes [] No
		[] Yes [] No			[] Yes [] No	[] Yes [] No
		[] Yes [] No			[] Yes [] No	[] Yes [] No
		[] Yes [] No			[] Yes [] No	[] Yes [] No

List all **minors (17 years and younger)** that live in the assisted household. Attach additional sheets if necessary.

Name	Disabled?	Date of Birth	Relation to Head of Household
	[] Yes [] No		
	[] Yes [] No		
	[] Yes [] No		
	[] Yes [] No		

II. TOTAL HOUSEHOLD INCOME: List the **monthly amount currently** earned or a received (**or anticipated** in the next 12 months) by every person in the household. Attach additional sheets if necessary.

Name	Welfare/ TANF	Salary/ Wages	SS/SSI	Child Support	Pension/ Retirement	Unemployment (weekly)	VA Benefit	Self Employed
	\$	\$	\$	\$	\$	\$	\$	\$
	\$	\$	\$	\$	\$	\$	\$	\$
	\$	\$	\$	\$	\$	\$	\$	\$
	\$	\$	\$	\$	\$	\$	\$	\$
	\$	\$	\$	\$	\$	\$	\$	\$

Voucher Applicant Employer(s) Attach additional sheets if necessary.

Name of Employer	Address	City	Zip	Phone

1. Is there **any other income received by any person in the household** that has not been listed on this form?
 No Yes If yes, received by _____ Monthly Amount \$ _____
2. Has the Voucher applicant worked a temporary or seasonal job in the past 12 months? No Yes
3. Does the Voucher applicant anticipate any change in income during the next 12 month period? No Yes

III. ASSETS

1. Does the Voucher Applicant own or have any interest in any **asset valued at \$1,000 or more**? No Yes
 If Yes, check all that apply: Bank/Credit Union Account \$ _____ Property/Real Estate \$ _____
 Other Asset _____ \$ _____
2. Does **any** household member have an **approved or pending** payment (for example annuity, insurance or accident claim/settlement; lottery or gambling winnings) No Yes Value \$ _____

IV. OTHER EXPENSES:

1. How much is the Voucher Applicant's monthly rent/mortgage? \$ _____
2. Check all utilities that you pay: Electric Water Garbage

Other specify :	
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V. QUALIFICATION FOR MEDICAL DEDUCTIONS

1. Is the Voucher Applicant or spouse disabled? No Yes
2. Is the Voucher Applicant or spouse 62 years or older? No Yes
3. Does the Voucher Applicant anticipate any unreimbursed medical expenses in the next 12 months? No Yes
 Mark type and indicate amount below:
 Medical Premiums \$ _____ Doctor/Hospital Co-Pay \$ _____ Medications \$ _____ Other \$ _____
4. If yes, does the Voucher Applicant expect to pay the expense one-time or will it be ongoing?

VI. ATTACH INCOME INFORMATION SUPPORTING YOUR NEED FOR ADUC FINANCIAL SUPPORT:

- IRS tax form with Schedule A **(white out social security # information)**
- Proof of federal assistance
- Other _____

WARNING: *I certify that I have supplied accurate and complete information. I understand reporting of **false or incomplete information is fraud** and may result in **denial or termination** of assistance. I realize that as the Voucher Applicant I am responsible for insuring that the information is complete and accurate for all household members.*

Signature of Applicant _____ **Date** _____

Adult Parent/Guardian _____ **Date** _____