**APPLICATION FOR PET HEALTH FINANCIAL ASSISTANCE**

***FROM BRANT ANIMAL AID FOUNDATION***

**FOR PET OWNERS RECEIVING GOVERNMENT SUBSIDIZED INCOMES**

**\*\*E-mail this application, client invoice & proof of eligibility to:** [**d.caskenette@sympatico.ca**](mailto:d.caskenette@sympatico.ca) **OR ask for pick-up \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. **Applicant (Name): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Please Print)**

**Full Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone Number: Home \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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1. **Proof of Eligibility:**

**The applicant is currently receiving financial assistant from (check appropriate box below to indicate which program) and attach copy of proof of program with this application/invoice.**

**ODSP ONTARIO WORKS COMSOC**



**GUARANTEED INCOME SUPPLEMENT**  **CPP DISABILITY**



**OTHER (SPECIFY) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**



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1. **Pet’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Dog Cat Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**



**Age: \_\_\_\_\_\_ Breed \_\_\_\_\_\_\_\_\_\_\_ Spayed: Yes No Neutered: Yes No**

**(Circle One above)**

**CONDITION OF PET WHEN SEEN & RESULTS OF EXAMINATION: (Please complete below):**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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1. **Name of Clinic: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ATTENDING VETERINARIAN NAME (Please Print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Cost of Treatment and/or Procedure: $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Amount (if any) to be paid by client to Vet office: $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Amount of funding requested from BAAF: $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*\*\*TO BE READ BY CLIENT & SIGNED BELOW: I understand that I will not be helped by BAAF with this pet again until it is spayed or neutered. This provision will not preclude financial assistance to an owner whose pet is suffering a terminal illness or if the procedure is deemed unnecessary by the veterinarian due to age or other factors.**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SIGNATURE OF VETERINARIAN**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SIGNATURE OF CLIENT**

**\*\*\*\*PLEASE NOTE: MANDATORY CONSENT FORM MUST BE SIGNED BY THE CLIENT/APPLICANT AND RETAINED IN THE CLIENTS FILE BY THE VET CLINIC/HOSPITAL\*\*\***

**\*Form revised: Jan 2018 + Feb 2012 + Apr 2011**