Dear Prospective Client:

Thank you for your interest in the Assistance Dogs of the West Owner/Self-Training Program. Before submitting your application, please call ADW to discuss your needs and schedule an appointment for an ADW trainer to meet with you and your dog to conduct a dog assessment. Payment for the dog assessment ($150) is due at the time it is scheduled. Both you and your dog must demonstrate the appropriate interests, temperaments and attributes to be successful candidates. An occupational therapy evaluation with Melissa Winkle of Dogwood Therapy Services (an independent occupational therapy provider) may be recommended following the client screening process.

Upon notification of a favorable assessment, you will complete the ADW Owner/Self-Training application and return it to: Assistance Dogs of the West, P.O. Box 31027, Santa Fe, NM 87594.

A COMPLETED APPLICATION MUST INCLUDE ALL OF THE FOLLOWING:

- Items 1-7 are included in the packet provided by ADW:
  - 1. ADW Client Services Fee Schedule
  - 2. Dog Medical History Health Statement Form to be completed by your veterinarian
  - 3. Completed Dog Profile Form
  - 4. Completed Program Application Form
  - 5. Completed Pre-Interview Form
  - 6. Medical History Form completed by your physician or primary care specialist
  - 7. A signed copy of ADW Privacy Practices

- Additionally, you will need to collect and include the following items with the ADW packet:
  - 8. A short autobiography
  - 9. Photographs: one of yourself, one of your dog, and some of your living environment, including indoor living spaces, your backyard, fencing (if applicable), and any pets living on the property.
  - 10. A letter of personal reference from a friend, co-worker, or someone other than a family member.
  - 11. A professional letter of reference from a therapist, social worker, teacher, or other professional with whom you have contact.
  - 12. Check, money order, or credit card payment for the $75 application fee.

ADW will only accept application packets that include all of the above listed items (1 through 12). Use this page as a checklist and keep copies of all completed forms for your records.

Once ADW has assessed your dog and received your complete application, you would be eligible to enroll in Owner/Self-Training with your dog. ADW will begin your training with four (4) performance/skill development evaluation classes. If client skill development does not meet the required milestones, ADW will review client progress, and reserves the right to release the team from the program. Fees for the course are outlined in the following pages. Please note that our accrediting agency (Assistance Dogs International) requires that owner-trained teams work with us for a minimum of 6 months.

If you are diabetic, please contact our office for an additional medical history form to be completed by the physician that follows you for your diabetes. Occasionally new information identified during the interview process can change client acceptance status if a need is found that ADW cannot meet. You should also know that owner/self-trained dogs are not guaranteed to succeed and receive public access certification, as unacceptable behaviors and attitudes occasionally are identified through the training.

Thank you again for your inquiry and interest. Please do not hesitate to call with any specific questions you may have.

Sincerely,

Liz Napieralski
Administrative Director
OWNER SELF-TRAINER FEE SCHEDULE [B]

The Assistance Dogs of the West owner self-trainer program includes a private or group training option. Payment is due at the beginning of each phase.

I. INITIAL DOG ASSESSMENT AND APPLICATION       TOTAL $225 (NON-REFUNDABLE)
   - Dog Temperament Assessment by Assistance Dogs of the West    $150
Phase I is required of all owner self-trainers. The Dog Temperament Assessment must be completed with ADW trainer approval before continuing the process. Payment for the dog assessment is due at the time the appointment is scheduled.
   - Application Fee:                     $75

II. CLIENT SCREENING                        TOTAL $125 (NON-REFUNDABLE)

An appointment with an ADW trainer to discuss client needs.

An evaluation with Occupational Therapist, Melissa Winkle of Dogwood Therapy Services (an independent occupational therapy provider) may be recommended following the client screening process.

III. TRAINING SESSIONS                  TOTAL $900

PUBLIC ACCESS / TASK WORK / SCENT TRAINING
One-on-One training sessions
Once per week for 12 weeks

ADW will begin training with four (4) performance/skill development evaluation classes ($300). If skill development does not meet the required milestones, ADW will review progress with the client, and reserves the right to release the team from the program. If progress and training are satisfactory, the client will receive and invoice and schedule with ADW trainers to complete the remaining nine sessions ($600).
Most client-dog teams will require at least two 12-week blocks: one 12-week session in Task Work or Scent Training, and one 12-week session in Public Access Training. At the conclusion of the course of training, the ADI Public Access test will be administered to the client/dog team. If public access is not achieved after clients complete the initial two blocks in the training process, subsequent training will be charged at $75 per visit, or ADW will suggest additional blocks of training.

Additional client services fee and fundraising information:
Some external agencies provide assistance with funding assistance dogs. If you receive services from the NM Division of Vocational Rehabilitation (DVR), contact your counselor to initiate the process to obtain payment through their office. ADW will provide any necessary paperwork, but you must initiate the process.

If you have limited income, you can apply for a voucher to pay a portion of the client fee through the Assistance Dogs United Campaign (ADUC). Applications are available each year only during the months of April and May, and must be received by May 31 for consideration. You must apply directly to ADUC; ADW cannot provide the paperwork for this process. More information can be found at http://www.assistedogunitedcampaign.org/

If you would like to find other funding for your dog, ADW can offer suggestions. Some individuals have done fund raising for their fee raising the entire amount and more and others have written for grants. There are many options. ADW does not have scholarship money available for clients at this time.

I have read and understood the client services fee schedule:

Client name (print & sign): ________________________________

Date ____________________

Please sign and return this page with your application packet.

If you are receiving financial assistance from a third party, please have a representative complete their information below.

Name and Title ________________________________

Company ________________________________

Signature ________________________________

Phone Number ________________________________
1. In accordance with ADI standards, all dogs placed as assistance dogs must be neutered or spayed before receiving public access. Dogs in training under the age of 13 months are exempt.

2. ADW does not accept an "assistance" dog of a person with a disability into the training process until or unless the dog is neutered or spayed. It the dog passes the evaluation for acceptance it must be neutered or spayed before the training begins. Exceptions are made if the dog is younger, but by 13 months of age this must be completed.

3. OST puppies must complete the puppy vaccinations series (three DA2PP).

4. OST puppies must have rabies vaccination between 6 and 9 months of age.

5. Depending upon OST area of residence, heartworm and flea medications must be given at appropriate times of year.

6. Due to high incidence of kennel cough in NM, no dog exposed to kennel cough or exhibiting persistent cough will be allowed into any ADW facility until the cough is gone and/or the incubation period is over.
DOG MEDICAL HISTORY HEALTH STATEMENT FORM

Please complete this form and have your veterinarian sign it.

Owner’s Name: ____________________________________________

Address: ________________________________________________

________________________________________________________

Phone: (home) __________________________ (work) ______________

Dog’s Name: ____________________________________________

Birth date: __________ Sex: M F Neutered: Yes ____ No ______

Veterinarian Clinic and Veterinarian: _______________________

Address: ________________________________________________

Phone: _________________________________________________

Date of last physical exam: _________________________________

Date of last fecal exam: _________________________________

Problems noted: __________________________________________

________________________________________________________

Vaccination Record:

Please provide date of the most recent inoculations.

Attach a copy of vaccination certificates.

Rabies Date ________________________________
(36-month vaccine: yes no)

DHLPP
Bordetella
Corona virus

Medical History:
Has this dog ever been diagnosed as having:

Campylobacteriosis
Yersoniosis

Salmonellosis
Canine brucellosis
Leptospirosis
Cutaneous dematophytes

Has this dog ever been diagnosed as having a staphylococcus infection which was resistant to multiple antibiotics?

YES NO

Has this dog ever been diagnosed as having a nematode infestation which could cause larva migrans in people?

YES NO

If yes, was successful treatment implemented for this infestation?

YES NO

Has this dog routinely had problems with fleas or ticks?

YES NO

Has this dog ever bitten anyone?

YES NO

Please describe this dog's general state of health and any major or recurrent problems you have noted:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Veterinarian's signature: __________________________ Date: ____________

Name: __________________________

Address: __________________________

________________________________________________________________________

Vet's Telephone: __________________________
ADW Owner/Self-Training Program Dog Profile

Client name: _______________________________

Dog's name: _______________________________

Breed: _______________________________

Age: _________________

How long have you owned your dog? _______________________________________

Where did you get your dog? (Animal shelter, breeder, etc.) ______________________

Do you currently take your dog out in public with you?  □ Always  □ Sometimes  □ Never

Does your dog have any obedience training? Please explain:

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

What service tasks would like your dog to perform for you? _______________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________
Program Application

It is the policy of Assistance Dogs of the West that all applicants receive equal consideration and treatment. All evaluations and reviews will be on the basis of ADW ability to successfully provide resources to identified client needs, regardless of race, color, religion, gender, sexual orientation, marital status, age, national origin, physical handicap, disability, medical condition or ancestry. This commitment applies to all persons involved in the operations of the company and prohibits unlawful discrimination by any employee of ADW. Please note that at this time, Assistance Dogs of the West is not able to place dogs in group homes.

Mail all application materials to:
Assistance Dogs of the West
P.O. Box 31027
Santa Fe, NM 87594

Applicant Information:

First Name ___________________________ Last Name __________________
Address __________________________________________ Apt. # (if applicable)
City ___________________________ State/ Zip Code
Home Phone ( ) ___________________________ Fax ( )
Cell phone ( ) ___________________________ Email
Date of birth _______ Approx. weight _______ Approx. height _______ Gender _______

Parent/Guardian/Caretaker Information (if applicable):

Name(s): __________________________________________ Apt. Number __________
Address __________________________________________ Apt. Number __________
City ___________________________ State/ Zip Code
Home Phone ( ) ___________________________ Work Phone ( )
Cell phone ( ) ___________________________ Email __________

Emergency Contact:

Name: __________________________________________
Relationship to applicant: __________________________ Apt. Number __________
Address __________________________________________ Apt. Number __________
City ___________________________ State/ Zip Code
Home Phone ( ) ___________________________ Work Phone ( )

Applicant’s Place of Employment or Current School:

Address __________________________________________ Suite Number __________
City __________________________________________ State/ Zip Code __________
Work Phone ( ) ___________________________ Fax ( )
Marital Status: _____ Single _____ Married _____ Separated _____ Divorced _____
Other (please explain) _______________________________________________________

With whom do you live? (Check all that apply)
□ Alone       □ with Parent(s)       □ with Spouse or Significant Other
□ with Attendant □ with Roommate(s) □ Other: _____________________________________________

Do you have children?       □ yes □ no

If yes, how many and what are their ages?
____________________________________________________________________
____________________________________________________________________

What type of home do you live in?
□ Private home/House       □ Apartment       □ Dorm       □ Single Room       □ Mobile Home
□ Other (please explain): _____________________________________________

Do you have a fenced yard or an enclosed outside area?
____________________________________________________________________

What is the general size, height of fence, and location of the area?
____________________________________________________________________

Have you ever had a dog or dogs before? Please describe your experience with your dog/s.
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

Do other animals live with you or visit you frequently? If so, please describe them, including the breed, sex, and age. Who is responsible for the care of these animals?
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

____________________________________________________________________
Does anyone in your household have concerns or worries about having an assistance dog in your/his/her home? Does he/she not want to have a dog in the house? If so, please describe.

What is your primary disability?

Do you know the cause of your disability? If so, please explain:

Please list any secondary disabilities:

At what age were you disabled? ________

Is your disability progressive? ____ Yes ____ No

What are the effects of your disability in your daily living? (Check all that apply)

☐ Deafness ☐ Speech Impairment ☐ Reduced Stamina ☐ Hearing Loss

☐ Coordination Problems ☐ Limited Mobility ☐ Memory Loss ☐ Spasticity

☐ Slowed Development ☐ Vision Impairment ☐ Muscular Weakness

☐ Other: ________________________________

Do you have any problems with: (Check all that apply)

☐ Allergies ☐ Chronic Pain ☐ Heightened Emotions ☐ Depression

☐ Seizures ☐ Skin Sensitivity ☐ Balance ☐ Brittle Bones

☐ Heat/Cold Sensitivity

Do you use an aid or assistive device? (Check all that apply)

☐ Prosthesis ☐ Leg Brace ☐ Manual Wheelchair ☐ Electric Wheelchair

☐ Wrist Brace ☐ Hearing Aid ☐ Crutch/Cane ☐ Walker

Program Application 3 of 5
Do you have any of the following psychological conditions or disorders as diagnosed by a psychiatrist or psychotherapist? (Check all that apply)

☐ Agoraphobia  ☐ Anxiety  ☐ Bipolar  ☐ Depression (chronic or clinical)

☐ Dissociative Tendencies  ☐ Obsessive Compulsive Disorder  ☐ Panic Disorder

☐ Post Traumatic Stress Disorder  ☐ Schizophrenia  ☐ Social Phobia

☐ Other (please describe)  ________________________________

Do you have frequent or persistent problems with any of the following, even if not diagnosed by a psychiatrist or psychotherapist? (Check all that apply)

☐ Anger  ☐ Apathy  ☐ Crying  ☐ Disorientation  ☐ Fearfulness  ☐ Forgetfulness

☐ Insomnia/Difficulty Sleeping  ☐ Moodiness  ☐ Nervousness  ☐ Nightmares  ☐ Panic

☐ Restlessness  ☐ Sadness  ☐ Social Withdrawal  ☐ Other  ________________________________

What kind of assistance dog are you looking for? (Check all that apply):

☐ Service  ☐ Home Helpmate  ☐ Seizure Response  ☐ Psychiatric Support

☐ Diabetic Alert  ☐ Facility  ☐ Courthouse Facility  ☐ Emotional support (No Public Access)  ☐ Other: ________________________________

Clients are required to travel to the Assistance Dogs of the West office in Santa Fe, NM for evaluation and multiple interviews over the course of the placement process. I understand, and am able to travel for these appointments: _____ Yes _____ No

If no, please explain:

____________________________________________________________________________________

____________________________________________________________________________________

Please Note: ADW has a broad profile of the successful candidate for placement of an assistance dog. The more information that you can share with us, the better ADW will be able to determine the type of assistance/support you require. Occasionally, after acceptance in our program, new information is identified through the interview process that can change the client acceptance status. If a critical client need is identified that an ADW dog cannot meet, ADW reserves the right to change the acceptance status. This is done with careful consideration of the client needs and ADW dog abilities and the mutual desire for a successful outcome for all.
All application information is true and complete to the best of my knowledge:

Applicant Signature ___________________________ Date ________________

If the applicant is a minor or 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.

Parent or Guardian Name: ___________________________

Relationship to applicant: ___________________________

Parent or Guardian Signature __________________________ Date ________________
OST Applicant Name:

Please Print Name

Please include the following information along with this form:

1. A short autobiography to help us know you better
2. A recent photo of yourself
3. A photo of your dog

1. How did you learn about our program?

2. What are you interested in having an assistance dog do for you? Why?

3. Do you need an assistance dog backpack for: [Check all that apply]
   - Pulling
   - Carrying items
   - Balance
   - Won’t use
   - Identification
   - Other:
4. Please rate your ability in the following areas.

How well do you:

<table>
<thead>
<tr>
<th></th>
<th>Normal</th>
<th>Some Difficulty</th>
<th>Much Difficulty</th>
<th>Unable</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Pick up items off the floor?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. Push elevator buttons?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C. Turn lights on and off?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D. Push a manual wheelchair?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E. Flex your wrist?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F. Make a fist?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

5. Please check all that apply to you:

A. What, if any, assistance devices do you use?
   - Manual chair
   - Electric chair
   - Scooter
   - Walker/Crutches

B. Check the types of transfer that you use:
   - Standing
   - Pivoting
   - Slide board
   - With help
   - Other:

C. How is your speech?
   - Clear-rapid
   - Clear-slow
   - Slurred
   - Difficult to understand

D. How do you best communicate verbally?
   - Voice
   - Letter board
   - Interpreter
   - Other:

E. How developed are your walking skills?
   - Short distances
   - Only with support
   - On level ground
   - Not at all

F. How high can you lift your arms?
   - Above your head
   - To your shoulders
   - Only slightly
6. Please rate your ability in the following areas.

<table>
<thead>
<tr>
<th>Area</th>
<th>Normal</th>
<th>Somewhat Limited</th>
<th>Very Limited</th>
<th>Unable to Speak</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Voice</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>B. Lung capacity</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>C. Hearing</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>D. Balance</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>E. Endurance</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>F. Mobility</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>G. Physical strength</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>H. Speed of reaction</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>I. Vision (with correction)</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
</tbody>
</table>

7. Are you: (Circle your answer)

- A. Extra sensitive to heat? Yes No
- B. Extra sensitive to cold? Yes No
- C. Extra sensitive to pain? Yes No
- D. Socially active? Yes No

8. What kind of activities are you involved in? (Check all that apply) Hours Per Week

<table>
<thead>
<tr>
<th>Activity</th>
<th>Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>O Work (paid or volunteer) outside the home</td>
<td></td>
</tr>
<tr>
<td>O Work (paid or volunteer) from within the home</td>
<td></td>
</tr>
<tr>
<td>O School</td>
<td></td>
</tr>
<tr>
<td>O Shopping</td>
<td></td>
</tr>
<tr>
<td>O Formal Exercise</td>
<td></td>
</tr>
<tr>
<td>O Recreational/entertainment activities outside the home</td>
<td></td>
</tr>
</tbody>
</table>

9. In general, please describe your home life, social activities, hobbies, lifestyle, and the type of community in which you live:
10. Do you belong to any clubs, groups, or community organizations? (Check all that apply)
   O Lions  O Veterans  O Civitans  O Rotary  O Kiwanis  O Elks  O Soroptimists
   O Alumni Association(s)  Other: ________________________________

11. Please check the boxes below that describe your living situation.
   O Animals in the household (Dogs # ___  Cats # ___  Other: ________________)
   O Fenced yard  O Enclosed outside area  O Park or yard nearby
   O Neighbors in close proximity  O Busy streets nearby  O Neighborhood dogs running loose

12. Which of the following words best describes the dog personality that might suit you best? (Check all that apply)
   O serious  O communicative  O distracted  O slow  O smart
   O playful  O friendly  O stubborn  O willing  O confident
   O energetic  O sensible  O no-nonsense  O responsible  O
   O protective  O resistant  O dependable  O stable  O
   O happy  O sweet  O easy-going  O excitable  O
   O independent  O assertive  O devoted  O calm  O
   O dependent  O loving  O trusting  O attentive  O

13. Rate yourself in the following areas:

<table>
<thead>
<tr>
<th></th>
<th>Very High</th>
<th>High</th>
<th>Average</th>
<th>Low</th>
<th>Very Low</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Enjoys people contact</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Likes to take risks</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Easily expresses emotions</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Likes to be in charge</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Easily bored with people</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. Determined to accomplish goals</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

14. Rate yourself in the following areas:

<table>
<thead>
<tr>
<th></th>
<th>Very High</th>
<th>High</th>
<th>Average</th>
<th>Low</th>
<th>Very Low</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Assertiveness</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Self-confidence</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
c. Ability to respond rationally to crisis

d. Ability to accept criticism or correction

e. Willing to learn new concept (even if different from previous beliefs)

f. Ability to laugh at oneself

g. Shyness

h. Sensitive to other’s emotions

i. Exuberance

j. Responsibility

k. Ability to control feelings/emotions

l. Desire to please others

m. Creativity

n. Independence

15. Please describe personal/physical care management practices that you have which you think might affect your Assistance dog placement:

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

16. Please describe how you think will handle the following areas of dog care:

   A. Feeding

   B. Grooming

   C. Toileting

   D. Veterinarian care

   E. Financial costs

   F. If you are hospitalized

   G. Flea problems

   H. Family/friend involvement

   I. Public Access issues

   J. Dog behavior problems
18. Assistance dog training program:

A. What specific difficulties might you have with a physically rigorous, emotionally demanding training program? ____________________________________________________________

B. What suggestions can you make to personally accommodate this training? ____________________________________________________________

C. What modifications might the training program make to accommodate your specific difficulties? ____________________________________________________________

D. How will you handle costs and time required to attend the Client Placement Training class? ____________________________________________________________

19. Do you currently receive any government benefits?  Yes  No

If yes, please identify: SSI ______ Veterans ______ Dept of Voc Rehab ________

Other: ____________________________________________________________

20. Please check the highest level of formal education completed:

  O Elementary school
  O Junior high
  O High school
  O Some post secondary classes
  O AA/AS degree
  O BA/BS degree
  O Master's degree
  O Doctorate
  O Other ____________________________________________________________
21. If you have any identified learning disabilities, please list them below:

________________________________________________________________________

________________________________________________________________________

Applicant Signature ___________________________ Date __________

Signature of Parent or Guardian ___________________________ Date __________
Assistance Dogs of the West Applicant Medical History Form
P.O. Box 31027 Santa Fe, New Mexico 87594 505-986-9748 info@assistancedogsofthewest.org

This form is to be completed by your physician and sent together with your other application materials.

Dr. __________________________

Please release the requested information regarding my condition to the above identified organization. This information will help determine my abilities in regards to the placement of an assistance dog.

Applicant’s Name (please print):

________________________________________________________________________

Applicant’s Signature:

________________________________________________________________________

Parent/Guardian Name/Signature (if applicable):

________________________________________________________________________

Doctor’s Name: ___________________________________________________________

Type of Practice: ___________________________________________________________

Address _________________________________________________________________

City __________________ State __________ Zip ______________

Phone (___) ___________________ Fax (___) __________________________

Patient Information:

What is this patient’s primary disability?

________________________________________________________________________

What was the cause of the disability?

________________________________________________________________________

Are there significant secondary disabilities?  Yes _____ No _____
If yes, please describe: __________________________________________

At what age was he/she disabled? _____ Is this disability progressive? Yes ____ No ____

Is there incapacity due to or affected by alcoholism or drug abuse? Yes ____ No ____

**What are the effects of patient’s disability? (Circle all that apply)**

- Deafness
- Speech Impairment
- Reduced Stamina
- Hearing Loss
- Coordination Problems
- Limited Mobility
- Memory Loss
- Spasticity
- Slowed Development
- Vision Impairment
- Muscular Weakness

Other: _________________________________________________________

**Does patient have any problems with: (Circle all that apply)**

- Allergies
- Chronic Pain
- Heat/Cold Sensitivity
- Depression
- Seizures
- Skin Sensitivity
- Balance
- Brittle Bones

Other: _________________________________________________________

**Does patient use an aid or assistive device? (Circle all that apply)**

- Prosthesis
- Leg brace
- Wheelchair (Electric)
- Wheelchair (Manual)
- Wrist Brace
- Hearing Aid
- Crutch/Cane
- Walker

Other: _________________________________________________________

**Does patient have any of the following psychological conditions or disorders? (Circle all that apply)**

- Agoraphobia
- Anxiety
- Bipolar
- Depression (chronic or clinical)
- Dissociative Tendencies
- Obsessive Compulsive Disorder
- Panic Disorder
- Post Traumatic Stress Disorder
- Schizophrenia
- Social Phobia
- Other (please describe) _______________________________________

**Does patient have frequent or persistent problems with any of the following? (Check all that apply)**

- Anger
- Apathy
- Crying
- Disorientation
- Fearfulness
- Forgetfulness
- Insomnia/Difficulty Sleeping
- Moodiness
- Nervousness
- Nightmares
- Panic
- Restlessness
- Sadness
- Social Withdrawal

Other (please describe) ________________________________________

**Does patient: (Check all that apply)**

- Drive
- Ride Bus
- Fly
- Driven By Others
- Travel Distances On Foot/Wheels

Other: _________________________________________________________

Current number of hours of attendant care per week: ____________

**ADL: Activities of Daily Living**
Is This Patient: (Please Circle Below)

A. Able to exercise judgment and make decisions necessary for ADL?
   Yes  Minimally  No

B. Able to sustain attention span?
   Yes  Minimally  No

C. Manifesting inappropriate behavior beyond his/her control?
   Yes  Minimally  No

D. Able to control physical and motor movement sufficient to sustain ADL?
   Yes  Minimally  No

E. Capable of perception and memory to the degree necessary to sustain ADL?
   Yes  Minimally  No

F. Able to follow directions and learn to the degree necessary to sustain ADL?
   Yes  Minimally  No

G. Under medication which impairs physical or mental functioning?
   Yes  Minimally  No

H. Capable of decisions concerning self and others needs and safety?
   Yes  Minimally  No

Can you recommend this individual for an assistance dog?
   Yes  No

Do you feel the Assistance Dogs of the West might benefit from consultation with you about this patient?
   Yes  No

Comments: ____________________________________________________________

______________________________________________________________________

Physician Signature: ________________________________ Date: ______________
ASSISTANCE DOGS OF THE WEST PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper or orally are kept properly confidential. This Act applies to all health care providers, it is intended to standardize health care information as well as ensure privacy and security of patient information. As a result of this act, this business would like to advise you of how we will protect the privacy of your or your child’s medical record.

As required by “HIPAA”, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

If you sign a consent form, we may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations

- **Treatment** means providing, coordinating or managing health care and related services by one or more health care providers. An example of this would be disclosure of your Protected Health Information (PHI) to providers outside this business such as your outside case manager, treatment team members, doctors, nurses and other health care providers in connection with your health care treatment.

- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities and utilization review. An example for this would be telling your health plan about treatment you are going to receive to determine whether your plan will pay for the treatment.

- **Health Care Operations** includes the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis and customer services. For example, we may also disclose PHI to doctors, nurses, therapists, students and other health care personnel for teaching purposes.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

**Legal Authority to make health care decisions for minors or others** Usually, the health information rights described in this Notice may be given to a person with legal authority to make health care decisions for a child or other person (for example, a parent of legal guardian). There are exceptions. For example, in New Mexico some health care services can be provided to a minor without the consent of a parent, guardian or other person. In these cases, the minor has the rights described in this Notice for health information related to the health care service provided.

We may without prior consent use or disclose protected health information to carry out treatment, payment or health care operations in the following circumstances:

- In emergency treatment situations, if we attempt to obtain such consent as soon as reasonably practicable after delivery of such treatment;

- If we attempt to obtain your consent but are unable to do so due to substantial barrier so communicating with you and we determine that in our professional judgment, your consent to receive treatment is clearly inferred from circumstances.
We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest of you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to our Privacy Officer or your therapist.

- The right to request restrictions on certain uses and disclosures of PHI including those related to disclosures to family members, close personal friends, or any other person identified by you. We are however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communication of PHI from us by alternative means or at alternative locations.
- The right to inspect and copy your PHI.
- The right to amend your PHI.
- The right to receive an accounting of disclosures of PHI.
- The right to obtain a paper of this notice from us upon request.

PERMITTED USE OR DISCLOSURE WITH AN OPPORTUNITY FOR YOU TO AGREE OR OBJECT

- **Research** as a professional medically based therapeutic center, we may use and disclose PHI about you for research purposes. We will only use and disclose your information for a research project if we obtain your permission or if the need to obtain your permission has been waived by a designated review committee that meets Federal requirements.

- **Promotional Communications** this business does not share or sell your PHI to companies that market health care products or services directly to consumers. This business may maintain mailing lists of individuals for promotional materials and news about ADW or training ideas. These include our newsletter and other information of this nature. You may be included on these lists. This business may send information about its programs and services to the individuals on these lists. If you wish to be removed from the mailing lists, please send written notice to ADW at P.O. Box 31027, Santa Fe, NM 87594

- **To Avert a Serious Threat to Health or Safety** we may use and disclose PHI about you when necessary to prevent a serious threat to your health and safety or the health and safety of others. Disclosure will only be to persons who could help prevent the threat.

- **To Have Supervised Students Providing Care** this business prides itself for remaining on the cutting edge of providing teaching assistance. One of the ways we maintain this status is by arrangements with student trainers and their families across our program. We have students and volunteers observing or doing rotations with ADW that last from a few days to the entire school year. Student trainers and volunteers are supervised by our staff according to the requirements of professional standards. If you object to having a student trainer or a volunteer involved in your interviewing or placement, please send written notice to ADW at P.O. Box 31027, Santa Fe, NM 87594

- **To Have Your Picture Taken** this business uses pictures of clients to use in the training process, in publications, to demonstrate specific training approaches, for training other clients, family caregivers, and ADW staff. We require written permission for photographing or videotaping a client or session prior to doing so. If you change your mind and decide that you no longer want our business to take images, we would like writing permission sent ADW at P.O. Box 31027, Santa
Fe, NM 87594. However, any images that this business had taken prior to this decision remain property of our business and we shall continue to use them.

USE OR DISCLOSURE PERMITTED BY PUBLIC POLICY OR LAW WITHOUT YOUR AUTHORIZATION

- **Military** we may disclose your PHI as required by military command authorities if you are in the armed services.
- **Workers Compensation** We may disclose your PHI for workers’ compensation or similar programs to the extent necessary to comply with laws relating to workers’ compensation or other similar programs established by law. These programs provide benefits for work-related injuries or illness.
- **Public Health Risks** as required by law, we may disclose your PHI for public health activities. For example, we may undertake these activities:
  - To prevent or control disease, injury or disability;
  - To report child abuse or neglect,
  - To notify a person who may have been exposed to a disease or may be at risk for contacting or spreading a disease or condition,
  - To notify the appropriate government authority if we believe a client has been the victim of abuse, neglect or domestic violence. We will only make this disclosure subject to certain requirements when mandated or authorized by law; and
  - To notify an individual that a client tells that they are intending harm, neglect or abuse in order to protect both at person and our client.
- **Lawsuit’s and Disputes** if you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose PHI about you in response to a subpoena, discovery request or other lawful process.

We are required by law to maintain the privacy of your PHI and to provide you with notice of our legal duties and privacy practice with respect to PHI.

This notice was effective as of April 14, 2003 and revised January 7, 2006 and we are required to abide by the terms of the notice of Privacy Practices and to make the new notice provisions effective for all PHI that we maintain. We will post this notice and you may request a written copy of a revised Notice of Privacy Practices from our office. If you want more information about HIPAA or believe your privacy rights have been violated, contact one or both of the following departments:

**Assistance Dogs of the West**  
P.O. Box 31027  
Santa Fe, NM 87594  
505.986.9748

OR

**Office of Civil Rights; US Department of Health and Human Services**  
1301 Young Street, Suite 1169  
Dallas, TX 75202  
200 Independence Avenue SW  
Washington, DC 20201

Phone (214) 767-4056  
Fax (214) 767-0432  
TDD (214) 767-8940  
Toll free: 1-877-696-6775

Please provide as much information as possible so your complaint may be properly investigated. You will not be penalized for filling a complaint.
Return a signed copy of this page to Assistance Dogs of the West

RECEIPT of PRIVACY PRACTICES
I have received a notice of privacy practices for my records. I understand that information regarding clients is privileged and not shared or distributed to anyone without my signed authorization.

Client Name (please print)  Date

Client Signature/Parent/Guardian signature