Thank you for your interest in a service dog from Assistance Dogs of the West. Please read this letter carefully and return the completed packet to ADW at P.O. Box 31027, Santa Fe, NM 87594. If you have any questions about the application, please feel free to call us at 505-986-9748 or email us at info@assistancedogsofthewest.org.

ADW is only accepting applications for psychiatric service dogs from veterans at this time.

A COMPLETE APPLICATION PACKET REQUIRES ALL OF THE FOLLOWING:

Items 1-5 are included in the packet provided by ADW:
- 1. ADW Client Services Fee Schedule
- 2. Completed Program Application Form
- 3. Completed Pre-Interview Form
- 4. Medical History Form completed by your physician or primary care specialist
- 4a. Medical History Form for Diabetic Alert Applicants (for diabetic clients only)
- 5. A signed copy of ADW Privacy Practices

Additionally, you will need to collect and include the following items with the ADW packet:
- 6. A short autobiography
- 7. Photographs: one of yourself, and some of your living environment, including indoor living spaces, your backyard, fencing (if applicable), and any pets living on the property.
- 8. A letter of personal reference from a friend, co-worker, or someone other than a family member.
- 9. A professional letter of reference from a therapist, social worker, teacher, or other professional with whom you have contact.
- 10. 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 10). Use this page as a checklist and keep copies of all completed forms for your records.

(Clients interested in a service dog for diabetic alert must review the criteria on the following page.)

Once we receive a complete application, it will be reviewed by ADW staff. Once review is complete, you will set an appointment with an ADW trainer to help us understand your needs, personality, and lifestyle. Then you will schedule Occupational Therapy evaluation with Dogwood Therapy (in Albuquerque, NM). All of this information is used to conduct a staff review to determine whether the applicant meets the profile for a successful placement candidate with an ADW dog. After the staff review, ADW will mail you client status notification letter. Client acceptance is conditional on an appropriate home visit, during which ADW staff will assess your environment for suitability in working with a service dog.

When applicants are notified of acceptance into the ADW program, the final step is the waiting list. Although the ADW waiting list is shorter than most service dog organizations, it averages six months to
two years to make a client/dog match. Client/dog interviews are conducted on a regular basis during this time to assess needs and potential matches. Occasionally new information identified during the interview process can change client acceptance status if a need is found that ADW dogs cannot meet. Once a match is made, the client is then scheduled for a two-week Client Placement Training (CPT) in Santa Fe. Fees for ADW client services are outlined in the following pages.

Requirements for obtaining a Diabetic Alert Dog (DAD)

This information is intended for prospective clients who are interested in receiving a Diabetic Alert Dog. If you are not applying for a Diabetic Alert Dog, please proceed to the next page.

ADW is committed to providing the best services to our DAD clients. To help foster a successful working partnership between clients and our DADs, as well as optimal use of our resources, we require the following in addition to the general requirements for applying for/obtaining an ADW assistance dog:

- Client must live in New Mexico and be able to attend regular training sessions (once per week) at our office in Santa Fe.
- DAD applicants need to have Type 1 diabetes, and have been diagnosed at least 2 years prior to application.
- Applicants need to be under the regular care of a physician and/or diabetes educator. Additional information will be required from the medical professional regarding the applicant’s diabetes and its management, by way of a form and discussions with ADW staff (if necessary).
- Applicants need to be taking all appropriate measures to monitor and control their diabetes, yet still be experiencing difficulty with blood glucose (BG) control.
- Applicants need to be experiencing a minimum of 3 hypoglycemic events per week.
- Applicants need to regularly monitor their blood glucose (several times per day, or as recommended by healthcare professional), using a glucometer and/or continuous glucose monitor. Note: use of a DAD will probably INCREASE the number of BG tests per day that the client must do.
- At the time of application, applicants need to provide glucometer or CGM data for the 3 prior months. If a significant lapse of time occurs between application and placement with a DAD, an additional month of data may be required.
- If the applicant works, they need to be able to take the DAD to work with them.
- Clients need to agree to provide BG records/graphs/data, including record of DAD alerts, to ADW for a minimum of 6 months after the DAD is placed with them, or as requested by trainers.
- Clients need to provide samples (saliva collected during low and high BG events) to ADW trainers for the purposes of training the DAD.
- Clients need to agree to work with ADW trainers on an ongoing basis for several months after placement with a DAD to further optimize the dog’s response.
- Clients need to agree to provide adequate rest periods for the DAD, as prescribed by ADW trainers.
- Client MUST accept full responsibility for the management of their diabetes, continuing all prescribed methods of monitoring and treatment after the DAD has been placed. A DAD is to be considered only one tool in disease management, and not relied upon solely.
CLIENT SERVICE FEE SCHEDULE

The Assistance Dogs of the West client/dog matching program is a three-stage process. Payment is due at the beginning of each stage unless otherwise arranged.

I. INITIAL ASSESSMENTS AND EVALUATION

<table>
<thead>
<tr>
<th>Description</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Application Fee*:</td>
<td>$75</td>
</tr>
<tr>
<td>(application will not be processed unless the $75 fee is included.)</td>
<td></td>
</tr>
<tr>
<td>Client Screening: Occupational Therapy Evaluation provided by Dogwood Therapy Services, an independent OT provider (1 hour); and Initial Interview by Assistance Dogs of the West (up to 2 hours),</td>
<td>$450</td>
</tr>
<tr>
<td>$525</td>
<td></td>
</tr>
</tbody>
</table>

II. UPON ACCEPTANCE

<table>
<thead>
<tr>
<th>Description</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interview Process</td>
<td>$1,500</td>
</tr>
<tr>
<td>Home, Public, and Workplace Visits included (if applicable)</td>
<td></td>
</tr>
<tr>
<td>(If a match is not made within the initial interview process [15 visits], subsequent interviews will be charged at $75 per visit)</td>
<td></td>
</tr>
</tbody>
</table>

III. CLIENT PLACEMENT TRAINING

<table>
<thead>
<tr>
<th>Description</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>CP Starter Pack</td>
<td>$350</td>
</tr>
<tr>
<td>Classes and Public Access Training</td>
<td>$3,750</td>
</tr>
<tr>
<td>$4,100</td>
<td></td>
</tr>
</tbody>
</table>

OUT OF STATE PLACEMENT FEE

To accommodate additional administration costs and trainers’ fees

$1,500

TOTAL COST: $6,125 NEW MEXICO RESIDENTS

$7,625 OUT OF STATE RESIDENTS

PRIVATE PLACEMENT:

ADW offers a private, in-home placement for those who are not able or do not wish to travel to Santa Fe for Client Placement Training. CONTACT OUR OFFICE FOR MORE INFORMATION ON THIS TYPE OF PLACEMENT.

TOTAL COST: $10,000 PLUS EXPENSES

(AIR TRAVEL, VEHICLE RENTAL, ACCOMMODATIONS)
Additional ADW Client Fee and Fundraising Information

PLEASE READ CAREFULLY AND RETURN A SIGNED COPY OF THIS PAGE WITH YOUR APPLICATION:

The $6,125 in-state and $7,625 out-of-state fee covers a portion of the ADW cost for client services. The total cost for preparing a dog for placement is approximately $15,000. This money is raised by ADW. Clients are encouraged to participate in additional fund raising activities if they are interested and able. Our most successful clients are those who play an active role in the entire placement process.

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.assistancedogunitedcampaign.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.

PLEASE RETURN A SIGNED COPY OF THIS PAGE WITH YOUR APPLICATION:

I have read and understood the client service fee schedule and fundraising information:

Client Name: _________________________________________________________     _________________________________________________________

Print                Sign
Date ______________________________

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/Contact Information
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 ________________________________________________________________________________ State/ Zip Code __________________________
City __________________________________________________ State/ Zip Code __________________________
Home Phone (_____) __________________________ Work Phone (_____) __________________________
Cell Phone (_____) __________________________ Email __________________________

Emergency Contact:
Name: __________________________________________________________ Apt. Number __________________________
Relationship to applicant: __________________________________________________________
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?
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Program Application 2 of 5
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

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
PRE-INTERVIEW FORM

Assistance Dog Applicant Name: ____________________________________________________________

Please Print Name

Please include the following information along with this form:

- A short autobiography to help us know you better
- A recent photo of yourself

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]
   O Pulling    O Carrying items    O Balance    O Won’t use    O Identification
   O 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>Excellent</th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Voice</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. Lung capacity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C. Hearing</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D. Balance</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E. Endurance</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F. Mobility</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>G. Physical strength</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>H. Speed of reaction</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I. Vision (with correction)</td>
<td></td>
<td></td>
<td></td>
<td></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

O Work (paid or volunteer) outside the home       ________
O Work (paid or volunteer) from within the home     ________
O School       ________
O Shopping       ________
O Formal Exercise       ________
O Recreational/entertainment activities outside the home _____

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 distracted  O calm
O playful  O stubborn  O attentive
O energetic  O no-nonsense  O smart
O protective  O dependable  O confident
O happy  O easy-going  O fearful
O independent  O devoted  O jealous
O dependent  O trusting  O submissive
O communicative  O loving  O excitable
O foolish  O,trusting

13. Which of the following words describe traits you would not want your dog to have? (Check all that apply)

O serious  O distracted  O slow
O playful  O stubborn  O willing
O energetic  O no-nonsense  O responsible
O protective  O dependable  O stable
O happy  O easy-going  O jealous
O independent  O devoted  O submissive
O dependent  O trusting  O excitable
O communicative  O loving  O calmat
O foolish  O trusting

14. Rate yourself in the following areas:

<table>
<thead>
<tr>
<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>
</tr>
<tr>
<td>b. Likes to take risks</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>
</tr>
<tr>
<td>d. Likes to be in charge</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>
</tr>
<tr>
<td>f. Determined to accomplish goals</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

15. Rate yourself in the following areas:

<table>
<thead>
<tr>
<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>
</tr>
<tr>
<td>b. Self-confidence</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Ability to respond rationally to crisis</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Ability to accept criticism or correction</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Willing to learn new concept (even if different from previous beliefs)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. Ability to laugh at oneself</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>g. Shyness</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>h. Sensitive to other’s emotions</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. Exuberance</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>j. Responsibility</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>k. Ability to control feelings/emotions</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>l. Desire to please others</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>m. Creativity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>n. Independence</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
17. Please describe how you think you 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 ________________

Parent or Guardian Signature __________________________________________________________________ Date ________________
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? (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: ____________________________________________________________________________

Does patient have any problems with? (Check all that apply)
_ Allergies  _ Chronic Pain  _ Heightened Emotions  _ Depression  _ Seizures  _ Skin Sensitivity
_ Balance  _ Brittle Bones  _ Heat/Cold Sensitivity  _ Other: ____________________________________________________________________________

Does patient use an aid or assistive device? (Circle all that apply)
(Check all that apply)
_ Prosthesis  _ Leg Brace  _ Manual Wheelchair  _ Electric Wheelchair  _ Wrist Brace  _ Hearing Aid
_ Crutch/Cane  _ Walker  _ Other: ____________________________________________________________________________

Does patient have any of the following psychological conditions or disorders?
(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) ____________________________________________________________________________

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 ____________________________________________________________________________

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

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

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

Comments: ________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Physician Signature: _____________________________________________ Date: __________
In addition to the general Medical History Form, this form is to be completed by the medical professional most familiar with your diabetes (physician, diabetes educator, etc.) 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 needs and abilities in regards to the placement of a diabetic alert 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:**

When was patient diagnosed with diabetes? Type 1 or Type 2? (circle one)

Treatments utilized (circle all that apply): diet tablets insulin injections insulin pump

Other (please describe) ____________________________________________

Please list medications prescribed for diabetes treatment: ____________________________________________
Diagnostics used regularly by patient (Circle all that apply): Glucometer CGM

Other (please describe) __________________________________________________________________________________________

How many times per day do you recommend that this patient test their blood glucose? _____

How many times per day, on average, does patient test their blood glucose? ______________

How many hypoglycemic episodes does the patient average per week? _______________

How many hyperglycemic episodes does the patient average per week? _______________

Most recent 3 HbA1c measurements: DATE: ______________ A1C: ______________

Does the patient exhibit hypoglycemic unawareness? Yes ____ No ____ Sometimes ____

Has the patient been hospitalized due to their diabetes in the past year? Yes ___ No ___

If yes, what was the reason? ____________________________________________________________________________________________

How often has the patient been seen by you in the last 2 years?

______________________________________________________________________________________________________________________________

When was the patient last seen by you? __________________________________________

Do you feel that this patient utilizes all appropriate methods to monitor, treat and control their diabetes (including lifestyle choices, blood glucose monitoring and medication compliance)? Yes ___ No ___ If not, why not? __________________________________________________________________________________________

Do you feel that this patient’s quality of life would improve significantly if his/her diabetes were under better control? Yes ___ No ___

Do you feel that 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 healthcare 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** 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
Phone (214) 767-4056
Toll free:1-877-696-6775

200 Independence Avenue SW
Washington, DC 20201
FAX (214)767-0432
TDD (214)767-8940

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 sSignature