



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.

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.
- 11. Veterans only: Veteran status certification documentation (DD-214)

ADW will only accept application packets that include all of the above listed items. 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. 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 TOTAL \$525

Application Fee:	\$75
Client Screening Initial Interview by Assistance Dogs of the West (up to 2 hours):	\$450 non-refundable

II. INTERVIEW PROCESS TOTAL \$1,500

Interview Process (upon acceptance into ADW's program):	\$1,500 up to 15 visits
Home, Public, and Workplace Visits included (if applicable)	
If a match is not made within the initial interview process [15 visits], subsequent interviews will be charged at \$75 per visit	

III. CLIENT PLACEMENT TRAINING TOTAL \$4,100

CP Starter Pack	\$350
Classes and Public Access Training	\$3,750

OUT OF STATE PLACEMENT FEE TOTAL \$1,500

To accommodate additional administration costs and trainers' fees

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. (Clients will still need to travel to Santa Fe for initial interview and interview process.)

TOTAL \$10,000 PLUS EXPENSES

(EXPENSES MAY INCLUDE BUT ARE NOT LIMITED TO: AIR TRAVEL, VEHICLE RENTAL, ACCOMMODATIONS)

*CONTACT OUR OFFICE FOR MORE INFORMATION ON THIS TYPE OF PLACEMENT

Additional 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 services provided by ADW. The total cost to raise and train each service dog is approximately \$25,000 per dog. This portion of the cost 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 for client training for 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. Mi Via, New Mexico's self-directed medical waiver, has also allowed client training to be put into the budget. 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.

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): _____
Address _____ Apt. Number _____
City _____ State/ Zip Code _____
Home Phone () _____ Work Phone () _____
Cell phone () _____ Email _____

Emergency Contact:

Name: _____
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?

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:

- 1. A short autobiography to help us know you better
- 2. 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]

- Pulling
 Carrying items
 Balance
 Won't use
 Identification
 Other: _____

4. Please rate your ability in the following areas.

How well do you:

	Normal	Some Difficulty	Much Difficulty	Unable
A. Pick up items off the floor?				
B. Push elevator buttons?				
C. Turn lights on and off?				
D. Push a manual wheelchair?				
E. Flex your wrist?				
F. Make a fist?				

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.

A. Voice	<input type="checkbox"/> Normal	<input type="checkbox"/> Somewhat Limited	<input type="checkbox"/> Very Limited	<input type="checkbox"/> Unable to Speak
B. Lung capacity	<input type="checkbox"/> Normal	<input type="checkbox"/> Somewhat Limited	<input type="checkbox"/> Very Limited	
C. Hearing	<input type="checkbox"/> Normal	<input type="checkbox"/> Somewhat Limited	<input type="checkbox"/> Very Limited	<input type="checkbox"/> Deaf
D. Balance	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
E. Endurance	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
F. Mobility	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
G. Physical strength	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
H. Speed of reaction	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
I. Vision (with correction)	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor

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

- Work (paid or volunteer) outside the home _____
- Work (paid or volunteer) from within the home _____
- School _____
- Shopping _____
- Formal Exercise _____
- 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)

- Lions Veterans Civitans Rotary Kiwanis Elks Soroptimists
- Alumni Association(s) Other: _____

11. Please check the boxes below that describe your living situation.

- Animals in the household (Dogs # _____ Cats # _____ Other: _____)
- Fenced yard Enclosed outside area Park or yard nearby
- Neighbors in close proximity Busy streets nearby Neighborhood dogs running loose

12. Which of the following words best describes the dog personality that might suit you best? (Check all that apply)

- serious indifferent distracted slow calm
- playful manipulative stubborn willing attentive
- energetic sensible no-nonsense responsible smart
- protective resistant dependable stable confident
- happy sweet easy-going jealous fearful
- independent assertive devoted submissive friendly
- dependent loving trusting excitable joking
- communicative foolish

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

- | | | | | |
|--|---------------------------------------|--------------------------------------|--------------------------------------|------------------------------------|
| <input type="checkbox"/> serious | <input type="checkbox"/> indifferent | <input type="checkbox"/> distracted | <input type="checkbox"/> slow | <input type="checkbox"/> calm |
| <input type="checkbox"/> playful | <input type="checkbox"/> manipulative | <input type="checkbox"/> stubborn | <input type="checkbox"/> willing | <input type="checkbox"/> attentive |
| <input type="checkbox"/> energetic | <input type="checkbox"/> sensible | <input type="checkbox"/> no-nonsense | <input type="checkbox"/> responsible | <input type="checkbox"/> smart |
| <input type="checkbox"/> protective | <input type="checkbox"/> resistant | <input type="checkbox"/> dependable | <input type="checkbox"/> stable | <input type="checkbox"/> confident |
| <input type="checkbox"/> happy | <input type="checkbox"/> sweet | <input type="checkbox"/> easy-going | <input type="checkbox"/> jealous | <input type="checkbox"/> fearful |
| <input type="checkbox"/> independent | <input type="checkbox"/> assertive | <input type="checkbox"/> devoted | <input type="checkbox"/> submissive | <input type="checkbox"/> friendly |
| <input type="checkbox"/> dependent | <input type="checkbox"/> loving | <input type="checkbox"/> trusting | <input type="checkbox"/> excitable | <input type="checkbox"/> joking |
| <input type="checkbox"/> communicative | <input type="checkbox"/> foolish | | | |

14. Rate yourself in the following areas:

	Very High	High	Average	Low	Very Low
a. Enjoys people contact					
b. Likes to take risks					
c. Easily expresses emotions					
d. Likes to be in charge					
e. Easily bored with people					
f. Determined to accomplish goals					

15. Rate yourself in the following areas:

	Very High	High	Average	Low	Very Low
a. Assertiveness					
b. Self-confidence					
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					

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 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:

- Elementary school
- Junior high
- High school
- Some post secondary classes
- AA/AS degree
- BA/BS degree
- Master's degree
- Doctorate
- 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 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)

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)

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
Diabetic Alert Dog Applicant Medical History Form**

P.O. Box 31027 Santa Fe, New Mexico 87594 505-986-9748 info@assistancedogsofthewest.org

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 ___

Any other 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 or 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 200 Independence Avenue SW
Dallas, TX 75202 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