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.

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.

<table>
<thead>
<tr>
<th>I. INITIAL ASSESSMENTS AND EVALUATION</th>
<th>TOTAL $525</th>
</tr>
</thead>
<tbody>
<tr>
<td>Application Fee:</td>
<td>$75</td>
</tr>
<tr>
<td>Client Screening Initial Interview by Assistance Dogs of the West (up to 2 hours):</td>
<td>$450 non-refundable</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>II. INTERVIEW PROCESS</th>
<th>TOTAL $1,500</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interview Process (upon acceptance into ADW’s program):</td>
<td>$1,500 up to 15 visits</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>

<table>
<thead>
<tr>
<th>III. CLIENT PLACEMENT TRAINING</th>
<th>TOTAL $4,100</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>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OUT OF STATE PLACEMENT FEE</th>
<th>TOTAL $1,500</th>
</tr>
</thead>
<tbody>
<tr>
<td>To accommodate additional administration costs and trainers’ fees</td>
<td></td>
</tr>
</tbody>
</table>

---

**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.assistancedogunitedcampaign.org/](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.

**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 ________________________________
Assistance Dogs International requires Assistance Dogs of the West to acquire additional documents/information required for the placement of service dogs for Veterans with Military-Related PTSD:

1. Please provide a copy of your veteran status certification documentation. (DD-214)

2. Please provide the names and contact information for two individuals who have agreed to provide support to you and your service dog. These individuals must agree to provide an immediate and temporary home for the dog should an emergency arise.

   **Support Person 1:**
   
   Name: ____________________________________________________________
   
   Phone: __________________________________________________________________
   
   Email: __________________________________________________________________

   **Support Person 2:**
   
   Name: ____________________________________________________________
   
   Phone: __________________________________________________________________
   
   Email: __________________________________________________________________

3. The veteran must sign a consent form that allows the program or its consultant to communicate directly with the veteran’s mental health provider or treatment team. (See attached release form.)

4. The veteran must provide written evidence that his/her family and/or support person(s) are knowledgeable regarding this application for a service dog and that they support the process, the placement of a service dog, and the follow-up of the team.
CLIENT PERMISSION TO OBTAIN/RELEASE INFORMATION

Client Name (please print clearly): ____________________________________________

Email: ___________________________ Phone: ______________

I understand that ADW has requested consent to communicate directly with my mental health provider or treatment team. By signature to this document, I give consent to Assistance Dogs of the West to release/obtain information concerning the diagnostic record and/or verbal exchange of information.

Information of mental health provider or treatment team:

Name ____________________________________________

Business Name ______________________________________

Address _________________________________________________

City, State, Zip _________________________________________

Phone __________________________________________________

Email ___________________________________________________

_________________________ ________________
Signature of Client (or Parent/Guardian if under 18 years of age) Date
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

<table>
<thead>
<tr>
<th>Applicant Information:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>First Name ________________________</td>
<td>Last Name ____________________________</td>
</tr>
<tr>
<td>Address ____________________________</td>
<td>Apt. # (if applicable)</td>
</tr>
<tr>
<td>City ____________________________</td>
<td>State/ Zip Code</td>
</tr>
<tr>
<td>Home Phone (____)</td>
<td>Fax (____)</td>
</tr>
<tr>
<td>Cell phone (____)</td>
<td>Email</td>
</tr>
<tr>
<td>Date of birth ______</td>
<td>Approx. weight ______</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Parent/Guardian/Caretaker Information (if applicable):</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Name(s): ________________________________________________________________</td>
<td></td>
</tr>
<tr>
<td>Address ____________________________</td>
<td>Apt. Number</td>
</tr>
<tr>
<td>City ____________________________</td>
<td>State/ Zip Code</td>
</tr>
<tr>
<td>Home Phone (____)</td>
<td>Work Phone (____)</td>
</tr>
<tr>
<td>Cell phone (____)</td>
<td>Email</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Emergency Contact:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Name: ________________________________________________________________</td>
<td></td>
</tr>
<tr>
<td>Relationship to applicant:</td>
<td></td>
</tr>
<tr>
<td>Address ____________________________</td>
<td>Apt. Number</td>
</tr>
<tr>
<td>City ____________________________</td>
<td>State/ Zip Code</td>
</tr>
<tr>
<td>Home Phone (____)</td>
<td>Work Phone (____)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Applicant’s Place of Employment or Current School:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Address ____________________________</td>
<td>Suite Number</td>
</tr>
</tbody>
</table>
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]
   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?
   O Manual chair   O Electric chair   O Scooter   O Walker/Crutches

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

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

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

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

F. How high can you lift your arms?
   O Above your head   O To your shoulders   O Only slightly

6. Please rate your ability in the following areas.

<table>
<thead>
<tr>
<th></th>
<th>Excellent</th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Voice</td>
<td>O Normal</td>
<td>O Somewhat Limited</td>
<td>O Very Limited</td>
<td>O Unable to Speak</td>
</tr>
<tr>
<td>B. Lung capacity</td>
<td>O Normal</td>
<td>O Somewhat Limited</td>
<td>O Very Limited</td>
<td></td>
</tr>
<tr>
<td>C. Hearing</td>
<td>O Normal</td>
<td>O Somewhat Limited</td>
<td>O Very Limited</td>
<td>O Deaf</td>
</tr>
<tr>
<td>D. Balance</td>
<td>O Excellent</td>
<td>O Good</td>
<td>O Fair</td>
<td>O Poor</td>
</tr>
<tr>
<td>E. Endurance</td>
<td>O Excellent</td>
<td>O Good</td>
<td>O Fair</td>
<td>O Poor</td>
</tr>
<tr>
<td>F. Mobility</td>
<td>O Excellent</td>
<td>O Good</td>
<td>O Fair</td>
<td>O Poor</td>
</tr>
<tr>
<td>G. Physical strength</td>
<td>O Excellent</td>
<td>O Good</td>
<td>O Fair</td>
<td>O Poor</td>
</tr>
<tr>
<td>H. Speed of reaction</td>
<td>O Excellent</td>
<td>O Good</td>
<td>O Fair</td>
<td>O Poor</td>
</tr>
<tr>
<td>I. Vision (with correction)</td>
<td>O Excellent</td>
<td>O Good</td>
<td>O Fair</td>
<td>O Poor</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 indifferent  O distracted  O slow  O calm
- O playful  O manipulative  O stubborn  O willing  O attentive
- O energetic  O sensible  O no-nonsense  O responsible  O smart
- O protective  O resistant  O dependable  O stable  O confident
- O happy  O assertive  O easy-going  O jealous  O fearful
- O independent  O sweet  O devoted  O submissive  O friendly
- O dependent  O loving  O trusting  O excitable  O joking

Pre-Interview 3 of 6
13. Which of the following words describe traits you would not want your dog to have? (Check all that apply)

<table>
<thead>
<tr>
<th>Word</th>
<th>O serious</th>
<th>O indifferent</th>
<th>O distracted</th>
<th>O slow</th>
<th>O calm</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>O playful</td>
<td>O manipulative</td>
<td>O stubborn</td>
<td>O willing</td>
<td>O attentive</td>
</tr>
<tr>
<td></td>
<td>O energetic</td>
<td>O sensible</td>
<td>O no-nonsense</td>
<td>O responsible</td>
<td>O smart</td>
</tr>
<tr>
<td></td>
<td>O protective</td>
<td>O resistant</td>
<td>O dependable</td>
<td>O stable</td>
<td>O confident</td>
</tr>
<tr>
<td></td>
<td>O happy</td>
<td>O sweet</td>
<td>O easy-going</td>
<td>O jealous</td>
<td>O fearful</td>
</tr>
<tr>
<td></td>
<td>O independent</td>
<td>O assertive</td>
<td>O devoted</td>
<td>O submissive</td>
<td>O friendly</td>
</tr>
<tr>
<td></td>
<td>O dependent</td>
<td>O loving</td>
<td>O trusting</td>
<td>O excitable</td>
<td>O joking</td>
</tr>
<tr>
<td></td>
<td>O communicative</td>
<td>O foolish</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

14. Rate yourself in the following areas:

<table>
<thead>
<tr>
<th>Area</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>

15. Rate yourself in the following areas:

<table>
<thead>
<tr>
<th>Area</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>
<tr>
<td>c. Ability to respond rationally to crisis</td>
<td></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>
<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>
<td></td>
</tr>
<tr>
<td>f. Ability to laugh at oneself</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>g. Shyness</td>
<td></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>
<td></td>
</tr>
<tr>
<td>i. Exuberance</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>j. Responsibility</td>
<td></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>
<td></td>
</tr>
<tr>
<td>l. Desire to please others</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>m. Creativity</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>n. Independence</td>
<td></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? _____________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Pre-Interview 5 of 6
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  ______________________
CLIENT PERMISSION TO RELEASE/OBTAIN INFORMATION:
This information will help determine my abilities regarding the placement of an assistance dog. I understand that ADW has requested consent to communicate directly with my physician and/or with my mental health provider or treatment team. By signature to this document, I give consent to Assistance Dogs of the West to obtain information concerning diagnostic record and/or verbal exchange of information.

Applicant’s Name (please print):

_______________________________________________________

Applicant’s Signature (or Parent/Guardian if under 18):

_______________________________________________________

The remainder of this form is to be completed by your physician or mental health practitioner/treatment team and sent together with your other application materials.

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)
Anger  Apathy  Crying  Disorientation  Fearfulness  Forgetfulness
Insomnia/Difficulty Sleeping  Moodiness  Nervousness  Nightmares  Panic
Restlessness  Sadness  Social Withdrawal
O  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: ____________
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 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:
  
  o To prevent or control disease, injury or disability;
  o To report child abuse or neglect,
  o 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,
  o 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
  o 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
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
GODPARENTS FOR YOUR ASSISTANCE DOG

We require each client to identify family, friends, or neighbors who can provide the care and management of your assistance dog in the event of an emergency, such as hospitalization. These persons should be your primary contact if you need immediate temporary housing for your dog. Your “godparents” should be able to meet your dog’s needs in a home environment.

GODPARENTS DO NOT HAVE PUBLIC ACCESS WITH YOUR DOG. They must know the proper feeding and safety requirements of your dog, but they should not be giving “commands” to your dog.

We recommend you select at least three “godparents,” so if one is not available, you may contact another. Make sure they all have contact information for each other. By assigning these individuals as godparents, you are granting ADW permission to be in contact with godparents as part of the application process.

Responsibilities of a godparent:

- To provide a safe living environment for the assistance dog while the client is unavailable to do so.
- To contact ADW immediately if the assistance dog comes into their care.
- To contact ADW immediately if they have questions or concerns about the care or management of the assistance dog.

ADW will discuss feeding, medication, and care with each client during Client Placement Training. ADW will provide a form that will be given to each godparent with the details of caring for the assistance dog.

Please notify ADW with contact information for your godparent(s) and any changes as they occur.
GODPARENT CONTRACT

Instructions: Fill in the contact information for each godparent below. Then, make 3 copies of the form and have each godparent sign the agreement at the bottom of the page. Submit these copies with your application.

CONTACT INFORMATION:

Name of Godparent: ____________________________
Address: ______________________________________
Phone Number: ___________ Mobile: ___________ Work: ______

Name of Godparent: ____________________________
Address: ______________________________________
Phone Number: ___________ Mobile: ___________ Work: ______

Name of Godparent: ____________________________
Address: ______________________________________
Phone Number: ___________ Mobile: ___________ Work: ______

Name of Handler: ____________________________
Name of Dog: ________________________________
Address: ______________________________________
Phone Number: ___________ Mobile: ___________ Work: ______

Assistance Dogs of the West:
PO Box 31027
730 St. Michael’s Drive, Santa Fe, NM 87505
505-986-9748

I ___________________________ (name of Godparent) agree to care for ____________________________‘s (client’s name) assistance dog in the event of an emergency if I am available at such time. I will be responsible for the temporary care of the dog until the handler can resume responsibility OR a staff member of Assistance Dogs of the West arrives.

Signature of Godparent: ____________________________