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**APPLICATION FORM FOR NEW LIFE FUND**

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| Owners Name  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Home Address Own Rent    \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Home/ Cell Phone  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Owner Email  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Employer (if currently working) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Work Phone  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Pets Name M F  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Breed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Ownership Duration Pet Birthday  \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_  Acquired Pet From  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Pet insurance? Y N  Policy #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Sprayed/ Neutered Y N  Vaccines Current? Y N | Condition needing treatment | Previous Estimates (when,who) |
|  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  |
| Annual house hold income:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Monthly rent/mortgage:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Number and age of people in household:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Request for Financial Assistance**

(Attach financials – Last year’s taxes, 3 months of bank statements and similar documents showing hardship)

**In signing this application, I understand and agree to the following:**

I declare that I have exhausted all alternative options available to me for financial assistance, however, I agree to reimburse Hannah’s Helping Hands with funds received upon a substantial change in my financial circumstances within the next six months. In addition, I hereby assign to Hannah’s Helping Hands all rights to any amounts received from any insurance or other source of recovery related to the care of this Pet. I do not operate any form of breeding facility for profit. I will provide financial documents in support of this request and I have owned my pet for at least a month. I agree to have my pet spayed/neutered during or after the treatment provided, if it is not already. I understand that Hannah’s Helping Hands is not responsible for the treatment and/or result of any veterinary services provided and hereby waive any and all claims for liability against Hannah’s Helping Hands or their providers. I understand and agree that Hannah’s Helping Hands hereby reserves the right to deny a Request for Financial Assistance to anyone for any reason and that Hannah’s Helping Hands is not financially responsible for charges incurred at a treating veterinary hospital prior to the submission of this application or after the above condition is treated. I agree that all approved medical treatments will be performed at a Hannah the Pet Society hospital and that once approved for funding through Hannah’s Helping Hands, I will have the option to become a Hannah the Pet Society Member prior to treatment at a greatly reduced rate. I authorize Hannah’s Helping Hands to use my and/or my pet’s photograph and any information relating to the payment of funds pursuant to this application for any purpose. When possible I agree to volunteer for Hannah’s Helping Hands special events and fundraisers. I declare, under penalty of perjury, that the foregoing is true and correct to the best of my knowledge.

**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Owner Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please submit this application by emailing it to** info@hannahscharity.org

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| Chief of Staff approval: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hospital \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Telephone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ $treatment Estimate \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Diagnosis \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Prognosis \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Recommended Procedure \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Expected Outcome \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Hospital Use Only:

Office Use Only:

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| APPLICATION STATUS Approved for:  Denied -- Reason Denied: | |
| EXECUTIVE DIRECTOR SIGNATURE | DATE OF APPLICATION DECISION |