UDS SERVICE DOGS
RECIPIENT APPLICATION

The popularity of service dogs is increasing and currently our waiting list could be as long as 3 years. We currently use Golden Retrievers, Labrador Retrievers and Boxers in our program. We try to work with our clients with specific allergy requirements.

Our program offers one-on-one client training. Our clients receive individualized training designed specifically for their individual needs. We do require that our clients attend some training sessions at our training facilities in Smoketown, PA.

The estimated value of a service dog is over $20,000. UDS Service Dogs charges each person who receives a trained service dog $5,000.00. Our fee is based on the individualized training we give to each client and the amount of monies already invested in training each service dog. A Payment plan may be available based on financial need. You may discuss this with the Program Manager.

Please take into consideration the ongoing expenses of having a service dog before returning the application documents along with a $25.00 application processing fee. This is a commitment that will require ongoing dedication in order for you and your service dog to achieve success.

If you would like more information on applying, contact Jill Harris, Program Manager at (717) 397-1841.

Name ____Date __________________

Address____Phone ______________________

Place of employment ____

Address ____Phone _________________

____

Emergency Contact _____________________________________Relationship_____________

Address ____Phone _________________

____

What is your primary disability? ____

What is the cause of your disability? ____

Are there significant secondary disabilities? _____Yes _____No

Please describe____

At what age were you disabled? ________ Is your disability progressive? _____Yes ______No

Date of birth __________________ Weight _____ Height _____ Sex ____M ____F

Circle all that apply:

What are the effects of your disability?

Speech impairment	Reduced stamina	Hearing loss
Memory loss	Vision impairment	Spasticity
Coordination problems	Deafness	Muscular weakness
Limited mobility	Slowed development	

Do you have any of the following problems?

Allergies	Chronic pain	Depression
Seizures	Balance	Brittle Bones
Heightened emotions	Skin sensitivity	Heat/Cold sensitivity

Do you use an assistive device?

Prosthesis	Leg brace	Walker
Wrist brace	Hearing aid	Crutch/cane
Wheelchair (electric)	Wheelchair (manual)	

Can you:

A. Pick up items off the floor?	Always	Often	Sometimes	Never
B. Push elevator buttons?	Always	Often	Sometimes	Never
C. Turn lights on and off?	Always	Often	Sometimes	Never
D. Push a manual wheelchair?	Always	Often	Sometimes	Never
E. Flex your wrist?	Left wrist	Right wrist	Neither	
F. Make a fist?	Left hand	Right hand	Not at all	

Do you:

Drive	Ride buses	Fly in airplanes
Travel distances on foot/wheels		Driven by others

Are you:

Single	Married

Do you live:

Alone	With Parents	Attendant
Spouse/significant other	Roommates	

Do you live with or have children, or do children visit regularly? _______Yes _______No

Number of children ___________Ages ____

Do you:

A. Use a:	Manual chair	Electric chair	Scooter	Walker/Crutches	
B. Transfer by:	Standing	Pivoting	Slide board	With help	
C. Is your speech:	Clear-rapid	Clear-slow	Slurred	Difficult	
D. Communicate best by:	Voice	Letter board	Interpreter	Other	
E. Walk:	Short distances	Only with support	On level ground	No	
F. Lift your arms:	Above your head	To your shoulders	Only slightly		
G. Exercise:	Regularly	Often	Sometimes	Infrequently	Never

Is your…

A. Voice:	Loud	Average	Soft	
B. Lung capacity:	Normal	Somewhat limited	Very limited	
C. Hearing:	Normal	Somewhat limited	Very limited	Deaf
D. Balance:	Excellent	Good	Fair	Poor
E. Endurance:	Excellent	Good	Fair	Poor
F. Mobility:	Excellent	Good	Fair	Poor
G. Physical strength:	Excellent	Good	Fair	Poor
H. Speed of reaction:	Excellent	Good	Fair	Poor
I. Vision (with correction):	Excellent	Good	Fair	Poor

Circle all that apply:

Are you:

A. Extra sensitive to heat	Always	Often	Sometimes	Never
B. Extra sensitive to cold	Always	Often	Sometimes	Never
C. Extra sensitive to pain	Always	Often	Sometimes	Never
D. Socially active	Always	Often	Sometimes	Never

Does your current living situation have:

Animals in the household:	Dogs	Cats	Other
A fenced yard	Enclosed outside area	Park or yard nearby	
Neighbors in close proximity	Busy streets nearby		
Neighborhood dogs running loose			

Do you:

Work/volunteer outside the home   Work/volunteer from/at home   Attend school
Shop – groceries, clothes, etc   Engage in recreation outside the home   Formally
exercise

Do you belong to any clubs, groups, or organizations listed below?

Lions	Veterans	GFWC
Rotary	Kiwanis	

What tasks/jobs are you interested in having a service dog do for you? Why?____________

____

____

Please describe personal/physical care management practices that you have which could affect the service dog placement.____

____

____

____

Please describe your home life, social activities, hobbies, and lifestyle in general.________________

____

____

____

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

A. Feeding ____

B. Grooming____

C. Toileting____

D. Vet care____

E. Financial costs____

F. If you are hospitalized____

G. Flea problems____

H. Family, friend involvement____

I. Access issues____

J. Dog behavior problems____

Are you the kind of person who:

Enjoys people contact?	Never	Rarely	Sometimes	Often	Always
Is a risk taker?	Never	Rarely	Sometimes	Often	Always
Easily expresses emotions?	Never	Rarely	Sometimes	Often	Always
Likes to be in charge?	Never	Rarely	Sometimes	Often	Always
Is easily bored with people?	Never	Rarely	Sometimes	Often	Always
Is determined to accomplish goals?	Never	Rarely	Sometimes	Often	Always

Rate yourself in the following areas:

Assertive	Never	Rarely	Sometimes	Often	Always
Self-confident	Never	Rarely	Sometimes	Often	Always
Ability to respond rationally to crisis	Never	Rarely	Sometimes	Often	Always
Ability to accept criticism/correction	Never	Rarely	Sometimes	Often	Always
Willing to learn new concept	Never	Rarely	Sometimes	Often	Always
Ability to laugh at self	Never	Rarely	Sometimes	Often	Always
Personal shyness	Never	Rarely	Sometimes	Often	Always

Are you able to travel for your interview? ____________Yes ______________No

If no, please explain.____

Do you currently have a pet?______________Yes _________No

If yes, list the type of pet, age and whether this is an inside or outside pet____________________

____

____

Applicant Signature____

If the applicant is a minor, under guardianship, conservatorship or a ward of the court, the parent or legally authorized representative is required to sign below pursuant to state or federal law.

Name (please print)____

Relationship____

Address____

Phone____

Parent or Legal Guardian Signature____

CONSENTTORELEASEINFORMATION

I, ______________________, hereby authorize UDS SERVICE DOGS to release and exchange information contained in my client records to the following individuals and/or organization, and only for the purpose listed below.

1. Name of person(s), organization and address to whom disclosure/exchange is to be made.

   UDSService Dogs Advisory Board

2. Specific type of information to be disclosed/exchanged.

   Physicalneedsaspertainingto Service dog work.

3. The purpose and need for such disclosure/exchange: To

   determinebestpossiblematchofconsumer&dog.

________________________________ ______ ____________

Consumer (Legal Guardian) Signature
Date Expiration Date

________________________________ ______

Witness Signature Date

I understand that I can revoke this consent at any time by signing my name below.

________________________________ ______

Consumer (Legal Guardian) Signature Date

________________________________ ______

Witness Signature Date

UDS Service Dogs
APPLICANT MEDICAL HISTORY FORM

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

Doctor's Name ________________________________Type of practice __________________

Address ____

City ______________________County ___________________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

Is so, please describe: ____

____

At what age was (s)he disabled? ______Is this disability progressive? ____Yes _____No

Is there an incapacity due to or affected by alcoholism or drug abuse? _______Yes _____No

Check all that apply:

What are the effects of your patient's disability? (Check all that apply)

____Deafness	____Speech impairment	____Reduced stamina
____Hearing loss	____Coordination problems	____Limited mobility
____Memory loss	____Vision impairment	____Slowed development
____Spasticiat	____Muscular weakness	Other: ____________________

Does patient have any problems with... (Check all that apply)

____Allergies	____Chronic pain	____Heightened emotions
____Depression	____Seizures	____Skin sensitivity
____Balance	____Brittle bones	____Heat/cold sensitivity

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

____Prosthesis	____Wheelchair(manual)	____Wheelchair(electric)
____Leg brace	____Wrist brace	____Hearing aid
____Crutch/cane	____Walker	Other: ____________________

Activities of Daily Living

Is this patient:	Please Circle Below
A. Able to exercise judgment and make decisions necessary for daily living?	Yes Minimally No
B. Able to sustain an 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 daily living?	Yes Minimally No
E. Capable of perception and memory to the degree necessary to sustain daily living?	Yes Minimally No
F. Able to follow directions and learn to the degree necessary to sustain daily living?	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 dog program might benefit from a consultation with you? _____Yes _____No

Comments:
____

____

Physician's Signature ______________________________________Date ________________________

FOR OFFICE USE ONLY

Date received ____________________________By____

Application complete?____

Application fee enclosed?__________________Check/Money Order/Cash__________________________

Date of interview__________________________Interviewer____

Accepted/Rejected______________________Reason for rejection____________________________