



Financial Assistance Program for Pet Spay/Neuter in Person County, North Carolina Animal Protection Society of Person County

Your Name:		Where did you get this application?											
Physical Address (of your home):													
City:	State:	Zip:	In what county do you live? PERSON COUNTY ONLY										
Mailing Address (if different from physical address):													
Daytime Phone:		Evening Phone:		E-mail:									
Your Age:	Number of Adults in Household (including you):			Number of Children in Household:									
<p>Important note about privacy: The information you provide will be used only for confirmation of your eligibility and will not be used for any other purposes. For additional protection of your private information, please mark through the Social Security numbers on all copies of documents.</p> <p>Provide a copy of the card or qualifying letter that proves a member of your household participated in one of the following programs to qualify:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 25%; border: none;">Adult Medicaid <input type="checkbox"/></td> <td style="width: 25%; border: none;">Child Medicaid (Health Choice) <input type="checkbox"/></td> <td style="width: 25%; border: none;">EBT Card (food stamps) <input type="checkbox"/></td> <td style="width: 25%; border: none;">Social Security <input type="checkbox"/></td> </tr> <tr> <td style="border: none;">Emergency Assistance (EA) <input type="checkbox"/></td> <td style="border: none;">Energy Assistance (EEF) <input type="checkbox"/></td> <td style="border: none;">Work First <input type="checkbox"/></td> <td style="border: none;">Social Security Disability <input type="checkbox"/></td> </tr> </table>						Adult Medicaid <input type="checkbox"/>	Child Medicaid (Health Choice) <input type="checkbox"/>	EBT Card (food stamps) <input type="checkbox"/>	Social Security <input type="checkbox"/>	Emergency Assistance (EA) <input type="checkbox"/>	Energy Assistance (EEF) <input type="checkbox"/>	Work First <input type="checkbox"/>	Social Security Disability <input type="checkbox"/>
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<p>OR, To qualify by income please provide a copy of page 1 of Federal Income tax Return for each adult in your household. What is your current household income per month from all sources (the amount before taxes are taken out)? _____</p> <p>Note about Income: If you think you qualify based on your current income but did not file taxes, or your income has decreased since last tax return, please enclose a note of explanation and your best proof of current income (for example, copies of W-2 forms, check stubs, benefit letters).</p>													
Please check here if you are a full-time student <input type="checkbox"/>													
Please list your pets that need spay/neuter surgery: (use reverse side if additional space is needed)													
Dog or Cat	Pet's Name	Sex	Description or Breed	Pregnant? In Heat?	Approx. Age	Approx. Weight							
<p>I understand that the Handy FIX-IT Fund is for pets owned by me-the applicant. The information I have provided about myself, my pets, and my household income is accurate and truthful. I have enclosed a photocopy of my card(s) or qualifying letter or the best proof I have of my total household income. Fraudulent use of the Handy FIX-IT Fund program will result in services charged to me at full price and possible legal action against me, and others involved in the fraudulent use of this service. In an effort to help as many families as possible receive help with their pets' needs, and to discourage families to continue to acquire pets when they cannot afford the medical expenses associated with them. The Handy FIX-IT Fund does not accept repeat applications from recipients. In other words, if approved, The Handy FIX-IT Fund will only assist you once.</p>													
<p>Signature: _____ Date: _____</p>													
<p>Please send completed application and photocopied documents to: Animal Protection Society of Person County, PO Box 291, Roxboro, NC 27573. If you need help filling out the application, please call 336-514-8689 or e-mail: apsofpc@gmail.com.</p>													
(Office use only) Reviewer	Date	Approved \$ ____ Co-Pay	Denied	Professional Referral (Name/Position/Contact Info)									