

**ANIMAL  
CARE  
FOUNDATION  
of Minnesota**



***Veterinarians helping  
people and their pets***

*P.O. Box 24525  
Edina, MN 55424*

*Phone: 763-529-5060*

*Fax: 877-419-1774*

*Clients@AnimalCareFoundation.org*

## **Client Application Instructions**

Thank you for taking the time to fill out this application as completely as possible. The information is necessary for us to determine if you meet the organization's eligibility criteria, to help match you to a clinic, and to provide the best possible care for your pet.

1. Gather your eligibility documentations. A list of acceptable forms of documentation is listed in the "Eligibility" section of this application.
2. Print and fill out this application.
3. If your pet has been vaccinated for Rabies or any other diseases; get a copy of the vaccination certificates or bill showing that they were given.
4. You may submit your completed application, eligibility documents, and your pet's vaccination records by one of the following means:

Emailing scans/photographs of application and attachments to:

[Clients@AnimalCareFoundation.org](mailto:Clients@AnimalCareFoundation.org)

Fax application and attachments to:

877-419-1774

Send application and attachments by Regular Mail to:

Animal Care Foundation

P.O. Box 24525

Edina, MN 55424

Note: Applications that are scanned/photographed and emailed/texted/faxed as attachments will be processed the fastest.

If you have any questions, please contact us at [Clients@AnimalCareFoundation.org](mailto:Clients@AnimalCareFoundation.org) or leave a voicemail at 763-529-5060. Our staff will get back to you as soon as possible.

Please remember that the Animal Care Foundation can only help with the medical care for one pet per family for that pet's life. ACF does not provide emergency or urgent care. When you fill out the form, please include only the information for that pet.



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**General Information**

Client Information:

Title:  Mr.  Mrs.  Ms.  Mx.

Home Phone Number: \_\_\_\_\_

First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Cell Phone Number: \_\_\_\_\_

Last Name: \_\_\_\_\_

Other Phone Number: \_\_\_\_\_

Address 1: \_\_\_\_\_

Email: \_\_\_\_\_

Address 2: \_\_\_\_\_

County: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Necessary Accommodations: \_\_\_\_\_

Zip Code: \_\_\_\_\_

Do you need help with transportation to your appointment?  Yes  No

Check here if you are homeless. Please designate a fixed location above. We will use this information to help us match you with a clinic that is as geographically accessible as possible. We will not use this location for mail unless you request us to do so.

Pet Information:

Pet's Name: \_\_\_\_\_

Gender (choose one):

Type:  Dog  Cat  Other: \_\_\_\_\_

Female (Intact\*)  Male (Intact\*)

Breed: \_\_\_\_\_

Female (Spayed)  Male (Neutered)

Weight: \_\_\_\_\_

\*Pet must be spayed or neutered within 6 months of being approved and matched to a member clinic for continued assistance.

Color: \_\_\_\_\_

Birthday: \_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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**Services Needed**

Type of Application:

- New Applicant: I have never been an ACF Client.  
 Applied and was accepted over a year ago. My ACF number is: \_\_\_\_\_

Type of Veterinary Service Needed:

Please indicate the type of medical care your pet needs (more than one may apply):

1. Preventative (check what is needed)

- Vaccinations       Heartworm Test       Fecal Parasite Test

2. Illness (briefly describe the problem)

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3. Other (please include any known medical history, attach an extra sheet if needed)

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Note: We are unable to provide urgent or emergency care.

Additional Information:

1. Name(s) of the veterinary clinic where your pet has received care in the past.

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2. Has your pet been vaccinated for Rabies?       Yes       No

If yes, send scans, copies, or photographs of documentation with application.

3. Has your pet been vaccinated for any other diseases?       Yes       No

If yes, send scans, copies, or photographs of documentation with your application.

## Eligibility

To qualify you must be able to respond yes to both of the following and provide documentation to support.

**Are you a resident of Minnesota?**  No  Yes

**Are you disabled or at least 65 years old?**  No  Yes

You must include copies, scans, or photographs of one form of proof from each of the categories listed below (A, B, C).

**Category A:** Proof of Residency (Provide one of the following.)

- A. Picture ID (Passport, Driver's License, State Issued ID)
- B. Copy of Utility Bill or Social Security/VA Disability Award Letter with Name and Address
- C. If you are homeless, sign here attesting that you are a resident of Minnesota.

X \_\_\_\_\_

**Category B:** Proof of being at least 65 years of age or being disabled. (Check 1 Box - showing which qualification you are claiming and provide one of the documents listed under that category.)

**I qualify because I am 65 or older:**

- A. Picture ID (Passport, Driver's License, State Issued ID) containing your birthdate.
- B. Birth Certificate showing your birthdate.

**I qualify because I am Disabled:**

- A. Social Security Disability (SSD) Award Letter or Supplemental Income (SSI) Award Letter or bank statement showing Direct Deposit of SSD or SSI-Please note, RSDI or straight SSA does not show you are disabled (unless you are under 65)
- B. Major VA Disability Award Letter equal to or greater than 50%.
- C. SMRT Certification from the state of Minnesota (May be shown on MNChoices Plan).
- D. Letter showing enrollment in MA-EPD (Medical Assistance for Employed Persons with Disabilities)

**Category C:** Proof that you meet income requirements (Provide one of the following.)

- A. Minnesota Medical Assistance - letter from Minnesota Care saying that you qualify for MA.
- B. Supplemental Security Income (SSI) Award Letter or bank statement showing SSI direct deposit.
- C. Snap Enrollment Form (Food Stamps)
- D. Enrollment letter from an MSP (Medical Savings Program) managed by the state of MN.
- E. Letter showing state or county is paying your Medicare Premiums.



## Signature Page

I confirm that the companion animal listed on my application (1) resides at my residence, and (2) is spayed/neutered or I have plans to do so in the next 6 months. I further confirm that I am (1) either disabled or over 65 years of age, (2) that I am in financial need, and (3) that the documents I provided are accurate and true. I acknowledge that falsifying or misrepresenting any of this information and accepting Animal Care Foundation veterinary services constitutes an act of fraud and that I may be subject to prosecution and penalties in accordance with municipal, state, and federal laws.

I authorize the release of receipts for my pet's care to the Animal Care Foundation from the member clinic I am matched with. These receipts may include information about the type of care provided, the dates of this care, and the costs for the care. The Animal Care Foundation will not share this information with any outside organizations.

I authorize the use of the images of my pet and myself (if applicable) by the Animal Care Foundation. These images, along with my pet's name and the general care they received, may be used for public promotion of the Animal Care Foundation. I further grant permission to creatively alter the images.

Check here if you want us to change identifiable information when telling your story (the name of your pet and your first name).

I understand that the ACF has limited resources and that occasionally a referral cannot be made even when a person qualifies. I understand that the ACF member clinics donate \$250 of care per year for each ACF client they accept that they are not reimbursed for.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please send me information about volunteering.

**Be sure to include (1) category A document, (2) category B document, (3) category C document, (4) completed signed application, and (5) a photo of your pet.**

Your application will ***not*** be processed until all the parts above have been received.

**Note: Meeting qualifications is no guarantee of veterinary service. The Animal Care Foundation and its member clinics reserve the right to refuse service to any client whose behavior affects the safety, security, comfort, or well-being of ACF staff, clinic staff, clients, or their animals. Only 1 animal per family for the life of that animal is eligible for ACF care.**



### Optional Demographic Information

**This form is entirely optional. It will not be connected to your application for assistance and will not impact your approval status. This information will be utilized to evaluate our effectiveness in reaching different populations, increase that effectiveness, and apply for grants and other financial assistance.**

1. Which category represents your age?

- |   |                                      |
|---|--------------------------------------|
| <input type="checkbox"/> under 18       | <input type="checkbox"/> 40-54 years |
| <input type="checkbox"/> 18 to 24 years | <input type="checkbox"/> 55-64 years |
| <input type="checkbox"/> 25 to 39 years | <input type="checkbox"/> 65+ years   |

2. If you are disabled, into which category (or categories) does your disability fall?

- |                                       |  |
|---------------------------------------|--|
| <input type="checkbox"/> Mobility     | <input type="checkbox"/> Mental Health Related |
| <input type="checkbox"/> Sight        | <input type="checkbox"/> Hearing               |
| <input type="checkbox"/> Speech       | <input type="checkbox"/> Developmental         |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> I am not disabled     |

3. Which category (or categories) best represents your race/ethnicity?

- |  |  |
|--|--|
| <input type="checkbox"/> Hispanic/Latinx                           | <input type="checkbox"/> Asian or Pacific Islander |
| <input type="checkbox"/> Black or African American                 | <input type="checkbox"/> White/Caucasian           |
| <input type="checkbox"/> Native American (Tribe affiliation _____) |  |
| <input type="checkbox"/> Other: _____                              |  |

4. Please rank your preferred languages for communication. Please choose at least one.

- |                                       |                                  |
|---------------------------------------|----------------------------------|
| <input type="checkbox"/> English      | <input type="checkbox"/> Spanish |
| <input type="checkbox"/> Hmong        | <input type="checkbox"/> Somali  |
| <input type="checkbox"/> Other: _____ |                                  |