10 Stacy's Way, Denmark, ME 04022
p. 207-653-6497 / f. 207-690-5769
www.sdsmaine.org

APPLICATION CHECKLIST

NAME: ____

Once completed, please send the checklist, application and required documents to SDS at the address or email below.

Our program is offered at NO COST to Survivors, although we do require a **$500 deposit** that will be refunded upon completion of the program.

In order to process your application, you must submit all the following documents:

1. The Application Checklist form, completed and signed.
2. The Application form, completed and signed.
3. Letter from your mental health care provider that **must** state:
    a. You are currently enrolled or will re-enroll in counseling for the duration of our program.
    b. You have a diagnosis of Post-Traumatic Stress Disorder as a result of Sexual Assault or Military Sexual Trauma (MST).
    c. A Service Dog is recommended as part of your overall treatment plan.
    d. You have given permission to your mental health care provider / counselor to speak with us if needed.
4. The HIPAA release form.
5. Copy of your DD214 with SSN / DOB redacted/blacked out (if a Veteran).

You must agree to the following (indicate your agreement by initialing each statement):

1. I am physically able to provide the necessary and adequate exercise for my dog. _____
2. I am completely responsible for the care and wellbeing of my dog. This includes but is not limited to food and routine veterinary care. _____

3. My living situation, work schedule, and family members are agreeable to having a dog. _____
4. I am the handler of my future Service Dog. This means I will not delegate primary responsibilities including exercise, training, or decision-making to any other individual. _____
5. Cats and dogs don't always get along. We strive to find dogs that tolerate cats, however these are animals and no guarantee can be given. If you have cat(s) and conflict arises between future Service Dog and existing cat(s), the cat(s) must be re-homed. _____
6. Our program requires meeting once a week for four hours of training, at an agreed upon day, time, and location, for twenty consecutive weeks. During that time, you are expected to train with your dog at home for a minimum of two hours a day, every day, and you must keep track of that training in a log our trainers will provide you. _____
7. You may miss one of the twenty weekly, supervised classes with no financial penalty. In case of family event, personal emergency, or short-term illness you must schedule a make-up class with our K9 trainers. Further make-up classes are your financial responsibility ($75/hr), however, we strongly encourage your presence at every training class as your presence as a team is so valuable to training for you, your Service Dog, and others in the class with you. ____
8. Once accepted into our program, you will work with us and our K9 trainers to select a suitable Service Dog candidate. At that point you will take full ownership and complete responsibility for the dog. _____
9. Our program is provided to you by our generous donors AT NO COST. We also ensure that you are given every opportunity to succeed. If you fail to successfully complete the program due to not following instructions, not putting in the work required, or by simply withdrawing, this life-changing opportunity will have been taken from a fellow Survivor / Veteran in need.
   I am fully committing to the requirements of this program! ____

Name: ______________________________

Signature: ___________________________

Date: _______________________________

SERVICE DOG APPLICATION

Full Name:____

Year of Birth: ____

Mailing Address:____

City___________________, **State**___________ **Zip**_________________

Residential Address: (if different from mailing address)

____

City___________________, **State**____________ **Zip**_______________

E-mail Address:____

Phone Number:____________________ ☐ **(Cell)** ☐ **(Home)** ☐**(Work)**

Best contact method and day / time to connect with you: ______________

____

May we text this number? Yes / No May we leave a detailed message? Yes / No

How did you hear about us? _____________________________________

QUESTIONNAIRE

(please circle or fill in your answer)

1. Have you been diagnosed with Post-Traumatic Stress Disorder as a result of Sexual Assault or Military Sexual Trauma? Yes / No

2. Are you a military Veteran? Yes / No (if No, please skip question 3)

3. Is your condition military service related? Yes / No

4. Describe your living situation, i.e. house, apartment, own, rent, yard, surroundings:

____

____

____

____

____

5. Are you employed? Yes / No

If yes, briefly describe your job duties and your hours.

____

____

____

____

____

6. Are you planning to take your Service Dog to work? Yes / No

7. Do you currently own a dog?

______Yes, and I would like my current dog to be my Service Dog.

Age of dog: Breed: Weight:

*Please note that all dogs must be evaluated by our trainer before entering our program.

(please skip to question 8)

______Yes, but I do not want to train my current dog to be a Service Dog.
(please answer the "no" question)

_______No. I need a dog.

What breed, age and size of dog do you envision having? ________________

____

____

8. Who else lives in your home? (please list all humans, your relationship to them and their age)

Name: __________________________ Relationship: _________________ Age: ______

Name: __________________________ Relationship: _________________ Age: ______

Name: __________________________ Relationship: _________________ Age: ______

Name: __________________________ Relationship: _________________ Age: ______

9. If any are children, are the children familiar with living with dogs? Yes / No

10. What other animals/pets are in your household?

Name: ___________ Type:_______________ Age: _______ Altered: Yes / No

☐This is my pet. How long have you had this pet? __________
☐This pet belongs to someone else in my household.

Name: ___________ Type:_______________ Age: _______ Altered: Yes / No

☐This is my pet. How long have you had this pet? __________
☐This pet belongs to someone else in my household.

Name: ___________ Type:_______________ Age: _______ Altered: Yes / No

☐This is my pet. How long have you had this pet? __________
☐This pet belongs to someone else in my household.

11. Other than PTSD, are there any other physical or mental health issues and/or limitations we should know about?

11. A future Service Dog will be trained to support you through a special bond you form with your canine partner. Are there specific tasks you would want a Service Dog to perform for you? Yes / No
If yes, please specify:

12. Do you have any other unique requirements? Yes / No
If yes, please specify.

I have read the above statements and I agree with the conditions of the program.

Printed Name: ____

Signature: ____

Date: ____

Please return this application and letter from your mental health care provider, along with a copy of your DD214 (if a Veteran) to Service Dog Strong by mail at:

Service Dog Strong
10 Stacy's Way
Denmark, ME 04022

Or by email at sdstrongme@gmail.com

We will contact you once we have received and reviewed your complete application package.

If you have any additional questions or concerns, please don't hesitate to call (207) 653-6497
or email us at sdstrongme@gmail.com.

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Health Insurance Portability and Accountability Act (HIPAA)

Release Form

Please complete all sections of this HIPAA release form. If any sections are left blank, this form will be invalid, and it will not be possible for your health information to be shared as requested.

Section I

I,____, give my permission for ____to share the information listed in Section II of this document with the person(s) or organization(s) I have specified in Section IV of this document.

Section II – Health Information

I would like to give the above healthcare organization permission to:

Check as appropriate:

- ☐ Disclose my complete health record including, but not limited to, diagnoses, lab test results, treatment, and billing records for all conditions.

OR

- ☐ Disclose my complete health record except for the following information:
  - ☐ Mental health records
  - ☐ Communicable diseases including, but not limited to, HIV and AIDS
  - ☐ Alcohol/drug abuse treatment records
  - ☐ Genetic information
  - ☐ Other (Specify)

    ____

    ____

    ____

Form of Disclosure: Hard Copy

Section III – Reason for Disclosure

Please detail the reasons why information is being shared. If you are initiating the request for sharing information and do not wish to list the reasons for sharing, write ‘at my request’.

____

____

____

____

Section IV – Who Can Receive My Health Information

I give authorization for the health information detailed in section II of this document to be shared with the following individual(s) or organization(s)

Name: ____

Organization: ____

Address: ____

I understand that the person(s)/organization(s) listed above may not be covered by state/federal rules governing privacy and security of data and may be permitted to further share the information that is provided to them.

Section V – Duration of Authorization

This authorization to share my health information is valid:

Check as appropriate

☐ a) From _____________to _________________

OR

☐ b) All past, present, and future periods

OR

☐ c) The date of the signature in section VI until the following event:

____

I understand that I am permitted to revoke this authorization to share my health data at any time and can do so by submitting a request in writing to:

Name: ____

Organization: ____

Address: ____

I understand that:

- In the event that my information has already been shared by the time my authorization is revoked, it may be too late to cancel permission to share my health data.
- I understand that I do not need to give any further permission for the information detailed in Section II to be shared with the person(s) or organization(s) listed in section IV.
- I understand that the failure to sign/submit this authorization or the cancellation of this authorization will not prevent me from receiving any treatment or benefits I am entitled to receive, provided this information is not required to determine if I am eligible to receive those treatments or benefits or to pay for the services I receive.

Section VI – Signature

Signature: ______________________________ Date: ________________________

Print your name: ____

If this form is being completed by a person with legal authority to act an individual's behalf, such as a parent or legal guardian of a minor or health care agent, please complete the following information:

Name of person completing this form: ___________________________________

Signature of person completing this form: ___________________________________

Describe below how this person has legal authority to sign this form:

____

____

____

____