Application to Receive Pet Rx MedicationAssistance

NH Strafford and Seacoast Rockingham Counties Only

Date: ___________________________

Name:____

Street Address: ____

Mailing Address (if different) : ____

City: ____ State: ___________ Zip:_______________

Phone numbers: ____

Email:____

Information About Pet's Veterinary Hospital:

Name of Your Veterinary Hospital/Veterinarian: ____

Address:___________________________________City: ______________________St: ___ Zip: ______

Phone number: ______________________________

Owner(s) name on pet records (if different from yours): ___________________________________

Pet Information: (Fill or Circle)

Pet Name: ___________________________________ Dog or Cat? M or F? Age: ________

Spayed/Neutered? Yes No Breed: ___________________________________

Approximate weight? ________________How long owned? ________________________

Do you have other pets? (Number and breeds, please) ____

Information About Your Income and Federal/State Assistance

Please check the form(s) of assistance you receive and ***SEND US A COPY OF THE AWARD DOCUMENT OR CHECK STUB AS PROOF OF YOUR RECEIVING AID.***

- ☐ Supplemental SSI
- ☐ Food Stamps (SNAP)
- ☐ OAA - Old Age Assistance
- ☐ ANB - Aid to Needy Blind
- ☐ APTD - Aid to The Permanently and Totally Disabled

- ☐ Direct relief from your city or town
- ☐ Medicaid Program
- ☐ Living entirely on Social Security
- ☐ Low Income (Separate form)

Notes: ___________________________________

____

Information About Your Pet's Medication Needs:

Medical Condition(s) of Concern: ____

How long has your pet been ill? ____

Medication and/or Prescription Diet Prescribed: ____

Approximate cost of medication per month: ____

Where is this medication obtained? (Vet or Pharmacy) ____

Does your pet require frequent rechecks and lab work? (Explain): _________________________________

____

Do you have the financial resources to meet the above requirements? (Explain) ____________________

____

☐ I give permisson for ElderPet to speak my veterinarian about my pet and the medication assistance requested.

I hereby attest that the information in this application is true and correct to the best of my knowledge.

____ _____________________

Signature Date

Please return this application and proof of financial eligibility (copy of award document or stub) to:

ElderPet
PO Box 624
Durham, NH 03824

Questions? elderpet@gmail.com; Jeri Zezula, Service Coordinator 603-767-6856