Application Checklist

Your application will be reviewed and an interview scheduled when all information has been received

- $150 Application Fee
- **Part A**- Client Portion of Application (pages 2-8)
  - **Part B**- (page 9)
    - Photo Outline
    - Two Letters of Recommendation
    - For Non-Active Military: A Copy of Your DD214 Form
- **Part C**- Medical Form (pages 10-13)
- **Part D**- (Military PTSD Applicant Only) (pages 14-17)
  - Mental Health Consultation Form
  - Two Support Individuals
  - Consent to Communicate with Mental Health Provider
  - Family / Support Person Form
JLAD will keep your entire application confidential. Your pictures and written application will become the property of JLAD

Please review the application instructions before completing this form. Your application will be reviewed, and an interview scheduled when all information has been received.

It is the Client responsibility to submit all of Part A and E, Part B: photo outline of your home/environment, and military form if applicable, Part D if applicable, and $150.00 application fee. It is also the client’s responsibility to follow-up with those who have been asked to complete a portion of this application to assure this is submitted in a timely manner.

APPLICATION PART A

First Name __________________________ MI _____ Last Name __________________________

Date of Birth: ______________ Age ______ Height ________ Weight ________ Sex M F

Address ______________________________________________________________________

Street City State Zip

Home Phone ______________ Work Phone ______________ Employer ______________

Cell Phone ______________ Email ________________________________________________

Name of Nearest Relative ______________________________________________________ Relationship ______________

Address of Relative __________________________________________________________________

Street City State Zip

Relative’s Phone Number ____________________ Work Phone ______________________________

This application must be IN THE WORDS OF THE PERSON WHO WILL USE THE DOG. If writing is difficult for you, provide name and relationship of person transcribing your words

Name __________________________ Relationship __________________________

How did you learn about JLAD? __________________________________________________

Military Personnel Only:

Do you have a military affiliation: __________________________________________________

What Branch? __________________________________________________________________

Are you active or retired? _________________________________________________________

For non-active military clients, please attach a copy of your DD214 form to this application
What are your expectations of the dog?
_________________________________________________________________________________________________________________
_________________________________________________________________________________________________________________
_________________________________________________________________________________________________________________
_________________________________________________________________________________________________________________
What is your disability?
_________________________________________________________________________________________________________________
_________________________________________________________________________________________________________________
_________________________________________________________________________________________________________________
Most JLAD dogs assist people with primary mobility impairment such as multiple sclerosis, muscular dystrophy, cerebral palsy, spina bifida, paraplegia, tetraplegia, arthritis, amputation, stroke, or traumatic brain or spinal cord injury. **JLAD does not train dogs to assist individual with seizure disorders, blood sugar disorders, or those with significant vision loss.**

Do you have any other diagnosis, including mental health diagnosis?
_________________________________________________________________________________________________________________
_________________________________________________________________________________________________________________
How long have you been disabled? _____________________________

If disability was caused by injury, what progress has been made post injury?
_________________________________________________________________________________________________________________
_________________________________________________________________________________________________________________

Please indicate the devices that you use:  
Wheelchair: ☐ manual ☐ power ☐ both
☐ Crutches ☐ Cane ☐ 3-wheel electric scooter ☐ Sip and puff
☐ Other __________________________________________________________

Which do you use most often? __________________________________________________________

Do you drive? ______ Take a bus? ______ Cab? _______ Other? _____________________________
Describe your physical strength and abilities. (Circle one number for each limb.)

<table>
<thead>
<tr>
<th></th>
<th>Available Use:</th>
<th>No Use</th>
<th>Full</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Left Side</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hand Dexterity</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arm Strength</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Upper-Body Strength</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leg Strength</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leg Control</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Right Side</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hand Dexterity</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arm Strength</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Upper-Body Strength</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leg Strength</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leg Control</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

How often do you fall? ____________________________________________________________

Can you catch yourself when you fall, or do you fall like a tree? ______________________

Please rate:  (On a scale of 1=Poor – to – 10=Normal)

**Your Speech?**  _____ Easily understood  _____ Tone variation  _____ Volume

Do you use a word board?  ☐ Yes  ☐ No  ☐ Other ____________________________

**Your Vision?**  _____ Do you use corrective lens?  ☐ Yes  ☐ No

Do you need?  ☐ Large font  ☐ Audio tape  ☐ Note taker  ☐ Other _________________

**Your Learning Ability?**  _____  ☐ Need assistance, namely __________________________

**Your Hearing?**  _____  ☐ Hearing Aid  ☐ ASL ________________________________

**How do you handle the following?**

- Routine medications  ☐ By yourself  ☐ Assisted  ☐ Provided by others
- Your finances, checkbook  ☐ By yourself  ☐ Assisted  ☐ Provided by others
- Housecleaning:  ☐ By yourself  ☐ Assisted  ☐ Provided by others
- Meals  ☐ By yourself  ☐ Assisted  ☐ Provided by others
- Getting dressed  ☐ By yourself  ☐ Assisted  ☐ Provided by others
- Shopping; groceries, etc.  ☐ By yourself  ☐ Assisted  ☐ Provided by others
- Personal Care  ☐ By yourself  ☐ Assisted  ☐ Provided by others
What personal attendants (including family members) do you use?

- Personal Care Aide
- Cooking
- Cleaning
- Medical
- Other __________

Describe how many attendants and how often? (Daily, weekly?) ________________

____________________________________________________________________

____________________________________________________________________

Please describe your limitations – mobility, physical strength, endurance, reaction speed, balance, vision, speech difficulties, heat, cold or pain sensitivity, your ability to read and understand written material, and anything that might help us understand your needs.

____________________________________________________________________

____________________________________________________________________

What work, school, or rehabilitation program(s) have you completed? ______________

What is your current work or school schedule? ________________________________

What are your plans for work or school? ________________________________

List the people living in your home, including their ages and their relationship to you.

____________________________________________________________________

____________________________________________________________________

_____________________________________________

_____________________________________________

_____________________________________________

Do any other members of your household have a physical or mental disability?
- No
- Yes If so, how are they disabled and what are their limitations?

____________________________________________________________________

Please describe your home and yard. ________________________________

____________________________________________________________________

Is your yard fenced?  - No  - Yes If yes, how high is your fence? ______

If your yard is not fenced, if your fence is too short or needs repair, will you be able to put up a secure fenced area before you receive your dog?
- Yes  - No

(Explain)______________________________
What pets do you have now? Describe type and age.
________________________________________________________________________
________________________________________________________________________

What is your veterinarian’s name and phone number?
________________________________________________________________________

If you have a dog now, would you be willing to give up your present dog, if it cannot get along with a JLAD dog?  □ Yes  □ No (Explain)
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

What dogs have you had before? Describe what kind and how old you were.
________________________________________________________________________
________________________________________________________________________

Have you ever re-homed a pet? If so, what was the reason?
________________________________________________________________________

On a daily basis, how will you handle walking, cleaning up after, feeding, medicating, exercising, grooming, and medical care for your trained dog?
________________________________________________________________________
________________________________________________________________________

Will it be difficult for you
  • to attend weekly training classes with your dog at our facility in Salem, OR
    □ Yes  □ No
  • to attend placement classes at the JLAD Training Center in Salem, Oregon for five hours a day for 2 weeks?
    □ Yes  □ No

Please explain any YES answer:
________________________________________________________________________
Do you agree to the following conditions?

That when your dog is in coat in public the dog will be kept on leash.

☐ Yes  ☐ No, explain

The dog being trained will spend most of their time with their partner at home AND at work, at school, and social events if he/she is certified for public access and that your trained dog will not be in a yard or kennel for long periods of time.

☐ Yes  ☐ No, explain

Your trained dog is not a family pet – he or she has a specific function in their partner’s life and minimal interaction with others.

☐ Yes  ☐ No, explain

That you and your dog are ambassadors for JLAD as well as for the entire assistance dog industry (guide, hearing, and service dogs) and you will be expected to maintain your dog’s appearance and manners, as well as your handling skills.

☐ Yes  ☐ No, explain

That your trained dog cannot be allowed off leash except in a secure area. Exercise and elimination must be done on leash or in a fenced yard or dog run.

☐ Yes  ☐ No, explain

That you must assume full responsibility as caretaker of your trained dog, in charge of their safety, health, and welfare. Their needs include:

- Medical care – all care prescribed by your veterinarian and routine annual care as directed by JLAD.  ☐ Yes  ☐ No, explain
• Nutritional care – including use of a good quality dog food and maintaining your dog’s proper weight.  □ Yes  □ No, explain

• Daily exercise and play  □ Yes  □ No, explain

That you assume full responsibility for maintaining appropriate training and behavior, updating your ADI public access certification every two years. You must maintain identification for public access, if applicable.  □ Yes  □ No, explain

That you must assume full responsibility for cleaning up after your dog if he eliminates in public and for repairing any damage caused by your dog.  □ Yes  □ No, explain

Sign below if you agree to the conditions listed above. Attach additional sheets if needed to explain any ‘No’ answer.

Signature of Applicant _____________________________ Date ________________
APPLICATION PART B

Photo Outline

Please provide pictures with Part A of your application. Include the following information and label the pictures with your full name be sure to address ALL of the items listed below.

Your pictures are critical. JLAD reviews it frequently during the placement process:

a. Initially, to see IF we can train a dog for your needs and accept you as a client
b. During custom-training of the dog to meet your needs

Show your environment
- Home – Interior and exterior of your home, your yard (including any fencing),
- Any present pets you may have.
- Family members
Other – Pictures of your work, school, recreational and/or social environment that may be

Letters of Recommendation

1) Personal (not a relative)
2) Professional (therapist, doctor)

We will need a physical letter from both people either included with the application or sent separately to JLAD.

Please send letters of recommendation to:

JLAD
PO Box 12023 Salem Or 97309
info@joydogs.org
APPLICATION PART C

Medical History Form

Please ask your physician or therapist to complete this form. Sign the release below and ask your physician to return it directly to JLAD.

Patient’s Last name _____________________ First ______________ Sex: ___ Date of Birth ______

Release of Medical Information

This authorizes you to release information regarding my condition to Joys of Living Assistance Dogs, Inc. This information will be used to evaluate and assess my situation and is essential for JLAD to train a service dog to increase my independence. All information is confidential.

Parental or duly authorized consent is required, pursuant to state and federal law, if client is a minor, or under guardianship or conservatorship/ward of the court.

Printed name _________________________________ Date ___________

Signature ____________________________________________________

Relationship or title and agency __________________________________________

Agency address and phone number

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

To the Physician or Therapist:

- We maintain confidentiality of our clients’ records. What you write here will not be shared with your patient unless you give express permission.
- If you have questions, please contact Joys of Living Assistance Dogs at (503) 551-4572. Please mail the completed form to:

  JLAD
  PO Box 12023
  Salem Or 97309
  info@joydogs.org

Practitioner’s Name: ___________________________________ Specialty: __________________

Address: ______________________________________________

Telephone: __________________________   Fax: __________________________

Date of last examination: _______________ Length of association with patient:
What is patient's primary diagnosis? ________________________________________________

What other conditions/diagnoses does the patient have?
______________________________________________________________________________

Prognosis for duration of impairment(s):
______________________________________________________________________________

Prognosis for progression of impairment(s):
______________________________________________________________________________

Prognosis for lifespan: ____________________________________________________________

Medications taken on a regular basis (please list):
______________________________________________________________________________

<table>
<thead>
<tr>
<th>How severe is the patient’s mobility impairment? (Please circle)</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
</tr>
<tr>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How severe is the patient’s visual impairment? (JLAD does not train dogs to assist visual impairment.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>None/correctible with glasses</td>
</tr>
<tr>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How severe is the patient’s auditory impairment? (JLAD does not train dogs to assist auditory impairment.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
</tr>
<tr>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How severe is the patient’s cognitive impairment?</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
</tr>
<tr>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Do limitations affect patient's ability to control his/her own behavior?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal</td>
</tr>
<tr>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How effective is the patient at handling and overcoming their limitations?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ineffective</td>
</tr>
<tr>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How reliable is the patient – on time for appointments, compliant with medications, etc.?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unreliable</td>
</tr>
<tr>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>To what degree do limitations affect patient’s ability to perform Activities of Daily Living* (ADL):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal</td>
</tr>
<tr>
<td>1</td>
</tr>
</tbody>
</table>
Activities of Daily Living (ADL) refers to the ability to meet personal care needs, i.e. feeding, bathing, dressing, etc., as well as the ability to perform tasks necessary for independent living, i.e., be compliant with therapy and medications, manage finances, maintain home, acquire outside services.

Cognitive and Emotional Evaluation of Patient:

A. Able to exercise judgment and make decisions necessary for ADL

B. Able to sustain attention span

C. Manifesting inappropriate behavior beyond his/her control

D. Able to control physical or motor movement sufficient to sustain ADL

E. Capable of perception and memory to the degree necessary to sustain ADL

F. Able to follow directions and learn to the degree necessary to sustain ADL

G. Under medication which impairs functioning

H. Capable of decisions about personal and others' needs and safety

Is incapacity due to or affected by patient’s alcoholism or drug abuse?  □ Yes  □ No

IF YES:

A. Has patient ever been in treatment facility? □ Yes  □ No

If yes, when and duration? ______________________________________________

A. Has permanent damage resulted? □ Yes  □ No

B. Has patient refused treatment or referral to a treatment center? □ Yes  □ No

Joys of Living Assistance Dogs may be skilled at the following tasks:

<table>
<thead>
<tr>
<th>Task</th>
<th>Task</th>
</tr>
</thead>
<tbody>
<tr>
<td>· Manners and obedience</td>
<td>· Enhance balance while walking</td>
</tr>
<tr>
<td>· Retrieve dropped articles</td>
<td>· Enhance balance while going up or down stairs</td>
</tr>
<tr>
<td>· Push Lifeline or 911 button</td>
<td>· Provide brace for transfers or getting up from floor/chair</td>
</tr>
<tr>
<td>· Find and retrieve phone</td>
<td>· Assist in pulling wheelchair</td>
</tr>
<tr>
<td>· Find help</td>
<td>· Retrieve adaptive equipment</td>
</tr>
<tr>
<td>· Retrieve from refrigerator</td>
<td>· Carry items in mouth or backpacks</td>
</tr>
<tr>
<td>· Push handicap buttons</td>
<td>· Take items to another person</td>
</tr>
<tr>
<td>· Turn lights off and on</td>
<td>· Specialized tasks as needed by client; e.g., assist with laundry, get the mail, tug shoes or coat off</td>
</tr>
<tr>
<td>· Open and close doors</td>
<td></td>
</tr>
</tbody>
</table>
JLAD dogs have good manners and basic obedience. Their job is to provide assistance with tasks and companionship. Your patient will gain control of part of their lives and receive unconditional love. Are there other ways in which you think your patient would benefit from having a service dog? If so, please describe:

__________________________________________________________________________________

__________________________________________________________________________________

Can you recommend that this patient have a service dog?  □ Yes  □ No

Why or Why Not?  ________________________________________________________________

__________________________________________________________________________________

Do you feel that the client is capable of properly caring for a service dog? This would include the daily physical needs of the dog as well as the substantial financial commitment a service dog requires. (we estimate $2000/ yearly)  □ No  □ Yes

May we contact you with questions?  □ No  □ Yes

Additional Comments or Remarks: ____________________________________________________

__________________________________________________________________________________

__________________________________________________________________________________

__________________________________________________________________________________

Signature of physician or therapist: _______________________________ Date: ____________

Mail to:
JLAD
PO Box 12023
Salem OR 97309
503-551-4572
APPLICATION PART D (Military PTSD only)

Mental Health Consultation Form

Please ask your mental health provider to complete this form, sign the release below, and ask your provider to return it directly to JLAD.

Client’s Last name _____________________ First ______________ Sex: ___ Date of Birth ______

Release of Medical Information

This authorizes you to release information regarding my condition to JLAD, Inc. This information will be used to evaluate and assess my situation and is essential for JLAD to train a service dog to increase my independence All information is confidential.

Parental or duly authorized consent is required, pursuant to state and federal law, if client is a minor, or under guardianship or conservatorship/ward of the court.

Printed name ____________________________ Date ___________
Signature ____________________________________________________________________________
Relationship or title and agency
_____________________________________________________________________________________
Agency address and phone number
_____________________________________________________________________________________
_____________________________________________________________________________________

To the Mental Health Provider:

- We maintain confidentiality of our clients’ records. What you write here will not be shared with your patient unless you give express permission.
- If you have questions, please contact JLAD at (503) 551-4572. Please mail the completed form to:

        JLAD  
        PO Box 12023  
        Salem Or 97309  
        info@joydogs.org

Provider's Name: ___________________________ Specialty: ________________________
Address: _________________________________________________________________________
Telephone: __________________________ Fax: ________________________________
What is patient's primary diagnosis? ____________________________________________

What other conditions/diagnoses does the patient have? ____________________________

Prognosis for duration of impairment(s):

____________________________________________________________________________

Prognosis for progression of impairment(s):

____________________________________________________________________________

Medications taken on a regular basis (please list): ___________________________________

Do limitations affect patient's ability to control his/her own behavior?

Normal 2 Moderate 4 Poor self-control 5
1 3

How effective is the patient at handling and overcoming their limitations?

Ineffective 2 Moderate 4 Very competent 5
1 3

How reliable is the patient – on time for appointments, compliant with medications, etc.?

Unreliable 2 Moderate 4 Very reliable 5
1 3

Please summarize the state of the Veteran’s mental health and treatment, including but not limited to addressing if the Veteran is actively suicidal and how he/she copes with anger management issues:

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________
Two Support Individuals

The Veteran must provide names and contact information of two individuals who have agreed to provide support to the service dog team. These individuals must also agree to provide immediate and temporary home for the dog should an emergency arise.

Contact #1:
Name: ____________________________________________________________
Address: _________________________________________________________________________
_________________________________________________________________________
Phone number: _____________________________________________________________
Email address: _____________________________________________________________________

Contact #2:
Name: ___________________________________________________________________________
Address: _________________________________________________________________________
_________________________________________________________________________
Phone number: ____________________________________________________________________
Email address: ____________________________________________________________________

Consent to Communicate with Mental Health Providers

I ___________________________ (Veteran name) hereby give the staff at JLAD or its consultant permission to communicate directly with my mental health provider or treatment team.

_________________________________________   _________________________
Signature                           Date
Family Support/Person Form
Veteran Letters of Support

We will need a physical letter from the Veteran’s family and or support person acknowledging their support of the Veteran’s application for a service dog, stating that they support the process, placement of the dog, and the follow-up of the team.

Please send support letter (s) to:

JLAD
PO Box 12023 Salem Or 97309
info@joydogs.org