

CARE GRANT APPLICATION

Confidential Information- for internal use only

*Please note: This application must be submitted by the veterinary clinic. **Pages 1-2 are for the veterinary clinic to complete, and page 3 is for the client to complete.** Please submit all documents together.*

Date: _____ Veterinarian's Name: _____

Clinic Name: _____ Clinic County: _____

Clinic Address: _____

Clinic Phone #: _____ Clinic Email: _____

Client Name: _____ Patient Name: _____

Dog Cat Other (specify): _____ Breed: _____

Age: _____ Female Male Spayed/Neutered? Yes No

Explain the financial circumstances that qualify this client for Care Grants (this question should be answered by the animal hospital, not the client- a brief summary of the client's financial circumstances is all that is needed):

Please provide a contextual description of the animal's overall health in addition to your diagnosis, treatment plan, and prognosis:

Finally, describe the relationship the client has with his/her pet and any additional information you want us to know for the decision-making process:

Please fill in the following:

Full value of invoice or estimate: \$ _____
(Attach itemized financial estimate or invoice)

Total diagnostic charges/costs, if applicable: \$ _____
(Diagnostics are not eligible for Care Grants)

Total financial contribution of the client: \$ _____

Total value of discounts provided by Clinic: \$ _____
(A meaningful discount must be applied by the clinic to qualify for Care Grants. Please include hospital discount as a line item on estimate/invoice. **If the clinic is discounting or donating certain items not shown on the estimate/invoice, please note this separately so we are fully aware of the clinic contributions to the care of the animal.**)

Net Care Grant amount requested: \$ _____
(Grants are subject to availability of funds and may not exceed \$500 per case.)

Please confirm you are submitting all of the following **required** items:

This application in full: Pages 1-2 completed by the veterinary clinic and page 3 completed by the client.

Itemized estimate for all services (with hospital discount shown)

Please note: If your care grant is approved, you must send in the final invoice before the check can be granted.

Pet's **digital** photograph

Submit to: **CVMA- Attn: Care Grants**

Via **Email:** info@colovma.org Or

Via **Fax:** 303.318.0450

Applications will be reviewed and approved upon receipt by the CVMA CEO and/or appointed designee. Notification of grant award decision will be made by the CVMA office within three (3) business days (Monday through Friday, excluding major holidays) of receiving complete application. Grant payments are paid directly to the veterinary clinic. Please allow 30 days for grant payment to be made.

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CLIENT CONSENT AND RELEASE

Date: _____ Veterinary Clinic: _____

Client's Name: _____ Pet's Name: _____

Client's Address: _____

Client Phone #: _____ Client Email: _____

In your own words, please describe in detail your relationship/bond with your pet and the effects of the medical condition described in this application. (Use back of sheet or attach separately if more room is needed)

Legal Consent *(Please acknowledge each box below by marking it with a checkmark or "x".)*

I/we understand that services will be performed for the animal named above by the veterinary staff at: _____
(write clinic name above)

I/we do not hold the CVMAF liable for veterinary medical care, including complications, death, additional fees beyond the grant, the need for future treatments, and/or any other circumstances arising from the treatment.

I/we agree to the use of any photograph(s) and stories (without the owner's specific identification) of my/our pet for educational/ promotional purposes of CVMAF (including but not limited to: brochure, newsletter, display, web site). I/we further understand that I/we will not be paid for the use of such photographs and stories.

I/we are the responsible person for the animal described above and are over the age of 18.

I/ we are willing to pay \$ _____ towards treatment. (No matter the amount, we ask each owner to contribute to the cost of the animal's treatment.)

Signature(s) of Owner or Agent

Date