



## APPLICATION CHECKLIST

To be eligible to enter Dog Tag Buddies' program you must be a veteran:

- Whose injuries took place during military service (stateside or deployed).
- In treatment with a licensed therapist (preferred) or currently enrolled with the V.A.
- Willing to submit to a criminal background check.
- Committed to taking the steps necessary to take charge of your life and your future.

**- Applicant Information** pages 3 – 12

**- DD214 and VA Certification of Disability**

- Email to [director@dogtagbuddies.org](mailto:director@dogtagbuddies.org) or mail in a copy to:

**Dog Tag Buddies**  
**PO Box 250**  
**Shepherd, MT 59079**

**- Authorization to disclose health information** pages 13 – 18

Sign the Provider's Release (Authorization to Disclose Health Information) on page 14, then send pages 14-18 (Authorization to Disclose Health Information and Medical Information) to your Provider(s) to complete.

**- Family Questionnaire** pages 19-22

Have a family member complete, sign, and mail directly to Dog Tag Buddies



# VETERAN

PO Box 250 ★ Shepherd, MT 59709 ★ 406.690.9853 ★ [director@dogtagbuddies.org](mailto:director@dogtagbuddies.org) ★ [dogtagbuddies.org](http://dogtagbuddies.org)

## APPLICATION PROCESS

1. Please type or print clearly with blue or black ink. Review and sign, then return documents either electronically to [director@dogtagbuddies.org](mailto:director@dogtagbuddies.org) or by mail to:  
**Dog Tag Buddies**  
**PO Box 250**  
**Shepherd, MT 59079**
2. Please include a copy of your DD214, VA Disability rating, and if applying for a service dog, a recommendation from your treating provider indicating a service dog may be useful in mitigating your disability.
3. Complete and sign the **Authorization to Disclose Health Information**. An original will be provided to your medical professional(s) and the signed copy will be included with your **DTB** application on file.
4. The Medical Information must be submitted by you to your provider and submitted to **Dog Tag Buddies** by the provider prior to acceptance into the program. If you have multiple providers, please submit to each provider.
5. Family questionnaire is to be completed by a parent, spouse, significant other, or a family member who currently resides with you. If you live alone, please have the document completed by someone who sees you at least on a weekly basis. Please have the individual who completes the document submit directly to **Dog Tag Buddies** electronically or by mail, address listed in #1 above.
6. Please note: Sending in the application is only the first step in the application process. Once application has been reviewed, any additional information needed will be requested from you, your care provider, or family member. Once all information has been reviewed, an interview will be scheduled. Following the interview, a background check will be conducted, and home inspection scheduled.
7. Once accepted into the program, **DTB** trainers will begin searching for an appropriate canine candidate. There is no specific timeline in which an appropriate candidate will be secured. **Dog Tag Buddies** is committed to find a dog that most closely matches your needs and will work with you during this time frame to prepare you for your canine companion.
8. While you are waiting for your canine companion, you will be required to attend training one (1) hour each week as an observer.
9. Once you are matched with your canine companion, you will commit to attending training one (1) hour each week at specific day/time.
10. If it is determined you are not a candidate for our program, you will receive a letter notifying you of the reason(s), and what steps if any, may determine future eligibility.



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## General Information

Date: \_\_\_\_\_  
 Name: \_\_\_\_\_  
 Address: \_\_\_\_\_ Apt: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Daytime Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_  
 Email address: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Sex: \_\_\_\_\_  
 Marital Status: Married    Single    Separated    Divorced

Are you currently employed? Yes                  No  
 Employer's Name: \_\_\_\_\_  
 Employer's Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Employer's Phone: \_\_\_\_\_  
 Occupation: \_\_\_\_\_

The highest level of education you have completed: \_\_\_\_\_

Primary Emergency Contact:  
 Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Secondary Emergency Contact:  
 Name: \_\_\_\_\_ Phone: \_\_\_\_\_

## Military Information

Veteran Status: \_\_\_\_\_  
 Military Branch: Army    Navy    Air-Force    Marines    Coast Guard    Dates of service: \_\_\_\_\_  
 Current Rank/Rank at time of discharge: \_\_\_\_\_ Type of discharge: \_\_\_\_\_  
 Honorable discharge: Yes                  No  
 In what war or conflict(s) did you serve: \_\_\_\_\_  
 Have you been diagnosed with Post Traumatic Stress Disorder and/or Traumatic Brain Injury? Yes    No  
 If **YES**, when and where was it diagnosed: \_\_\_\_\_



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Please list your disability(s) and limitation(s): \_\_\_\_\_  
\_\_\_\_\_

How long have you been disabled: \_\_\_\_\_

Do you require the assistance of an attendant? Yes                      No

If **YES**:

How often do you have an attendant? \_\_\_\_\_

What does your attendant do for you? \_\_\_\_\_

Is your attendant aware that you are applying for an emotional support dog or service dog? Yes    No

What are your expectations for/of your emotional support dog or service dog: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What is your mobility? \_\_\_\_\_

Have you experienced a spinal injury? Yes                      No

If **YES**, please list level of injury and details: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you have any other challenges in addition to your disability? Yes                      No

If **YES**, explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you able to walk? (Slowly, short distances, etc.) Yes                      No                      Normally

If **YES**, but limited, please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you able to perform everyday tasks such as:

Feeding yourself: Yes                      No

Dressing yourself: Yes                      No

Personal Hygiene: Yes                      No



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Maintain your own residence: Yes No

Manage your own finances: Yes No

Utilize outside services: Yes No

If your answer was **NO** to any of the above tasks, who does these things for you? \_\_\_\_\_

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## Housing Information

How many people live in your household? Please list name, age, and relationship to you:

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Relationship: \_\_\_\_\_

Are you, or is anyone, who lives with you, allergic to dogs: Yes No

If **YES**, to what extent? \_\_\_\_\_

Do you plan to move in the near future: Yes No To Where? \_\_\_\_\_

- Do you live in an:
- Apartment
  - Duplex
  - Mobile Home
  - House
  - Dorm
  - Other (please list): \_\_\_\_\_

If you **RENT**, Landlord's Name: \_\_\_\_\_

Landlord's Address: \_\_\_\_\_

Landlord's Phone: \_\_\_\_\_

Is your Landlord aware you are applying for a service dog? Yes No

Do you have a yard? Yes No Is it fenced? Yes No

## Civil / Criminal Charges

Have you ever had, or do you have, pending criminal charges? Yes No



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If **YES**, please explain: \_\_\_\_\_

Dates: \_\_\_\_\_

Have you served, or are you currently serving, parole or probation?      Yes                  No

If **YES**, please explain: \_\_\_\_\_

Dates: \_\_\_\_\_

Have you ever been charged with driving under the influence?      Yes                  No

If **YES**, please explain: \_\_\_\_\_

Dates: \_\_\_\_\_

Have you ever been charged with domestic violence?      Yes                  No

If **YES**, please explain: \_\_\_\_\_

Dates: \_\_\_\_\_

Have you ever been charged with animal cruelty?      Yes                  No

If **YES**, please explain: \_\_\_\_\_

Dates: \_\_\_\_\_

## Owning A Dog

Do you have any animals in your home at this time? Yes                  No

Please list all animals (name, age, type of animal, etc.): \_\_\_\_\_

Do you have any outdoor animals? Yes                  No



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If **YES**:

How many? \_\_\_\_\_

What kind? \_\_\_\_\_

Do they ever come indoors? Yes                      No                      When? \_\_\_\_\_

Please list all animals you have owned in the past 10 years (if **NOT** listed above) (name, age, type of animal, etc.): \_\_\_\_\_  
\_\_\_\_\_

Have you ever had a service dog from another agency? Yes                      No

If **YES**:

Name of the agency: \_\_\_\_\_

Address of the agency: \_\_\_\_\_

Phone number of the agency: \_\_\_\_\_

When did you receive this dog? \_\_\_\_\_

Where is the dog now? \_\_\_\_\_

How long did you have this dog? \_\_\_\_\_

If you've had more than one dog, were they from the same agency? Yes                      No

Will you be able to walk your dog yourself? Yes                      No

If **NO**, whom will you arrange to walk and clean up after your dog? \_\_\_\_\_

Will you be able to feed the dog yourself? Yes                      No

If **NO**, who will feed the dog daily? \_\_\_\_\_

How many hours a day will your dog be alone? \_\_\_\_\_

Explain: \_\_\_\_\_

How much will the dog travel with you? \_\_\_\_\_

Do you plan to take your service dog to work with you? Yes                      No

If **YES**:

Have you already discussed this with your employer? Yes                      No

Does your employer have any concerns about you bringing your service dog with you? Yes                      No



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If **YES**, Explain: \_\_\_\_\_

Have you ever had a negative experience with a dog? Yes                      No

If **YES**, please explain: \_\_\_\_\_

What breed was the dog? \_\_\_\_\_

Is there any breed you would NOT want as a service dog? Yes                      No

If **YES**, please explain: \_\_\_\_\_

Are you willing to accept full responsibility for your dog's health? Yes                      No

Will you accept full responsibility for your dog's behavior? Yes                      No

Do you have the facilities for regular exercise for the dog? Yes                      No

Describe the facilities: \_\_\_\_\_

Do you feel you have adequate knowledge of emotional support dog or service dogs and what their care involves? Yes                      No

If **NO**, are you willing to learn more about emotional support dogs or service dogs? Yes                      No

How do the other people in your household feel about you getting an emotional support dog or service dog?

\_\_\_\_\_

How do your friends feel about you getting a dog? \_\_\_\_\_

\_\_\_\_\_

How do you feel a service dog can help you? \_\_\_\_\_

\_\_\_\_\_

What is your primary goal you plan on achieving with your emotional support dog or service dog? \_\_\_\_\_

\_\_\_\_\_

The average food expense for a dog is \$250-\$300.00 or more annually. The veterinary expense for a dog is \$120-\$200.00 or more annually.

Can you afford this expense? Yes                      No





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If **NOT**, please explain: \_\_\_\_\_

What tasks do you want your emotional support dog or service dog to perform? Please list them in priority order:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_
8. \_\_\_\_\_
9. \_\_\_\_\_
10. \_\_\_\_\_

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## Personal Information

Please rate yourself in the following areas. High is 5, low is 1.

1. Enjoys contact with people: \_\_\_\_\_
2. Likes to take risks: \_\_\_\_\_
3. Easily express fear: \_\_\_\_\_
4. Easily express sorrow: \_\_\_\_\_
5. Easily express love: \_\_\_\_\_
6. Easily express anger: \_\_\_\_\_
7. Easily express joy: \_\_\_\_\_
8. Likes to be in control: \_\_\_\_\_
9. Easily bored with people: \_\_\_\_\_
10. Determined to accomplish goals: \_\_\_\_\_
11. Stand your ground: \_\_\_\_\_
12. Ability to respond rationally to crisis: \_\_\_\_\_



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- 13. Ability to accept criticism or correction: \_\_\_\_\_
- 14. Willing to learn new concepts, even if different from their own: \_\_\_\_\_
- 15. Self-confidence: \_\_\_\_\_
- 16. Ability to laugh at self: \_\_\_\_\_
- 17. Sensitive to other's emotions: \_\_\_\_\_
- 18. Personal shyness: \_\_\_\_\_
- 19. Accept responsibility of your actions: \_\_\_\_\_
- 20. Ability to control feeling or emotions: \_\_\_\_\_
- 21. Desire to please others: \_\_\_\_\_
- 22. Creativity: \_\_\_\_\_
- 23. How assertive are you in relating to people over a difference of opinion? \_\_\_\_\_

Did you need help to fill out this questionnaire? Yes                  No

We appreciate your time. The more we know about you, the easier it is to choose a dog with the right qualifications to work best with you.

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

To assists us in fund raising, please answer the following questions:

*Your answers to these questions are optional, not required. These questions are for statistical record keeping required by most grants. Your answers to these questions have no effect on your application whatsoever.*

Are you familiar with American Disability Act? Yes                  No

Are you on public assistance? Yes                  No

What form(s) of assistance do you receive? \_\_\_\_\_

Are you a client of Vocational Rehabilitation? Yes                  No

How did you hear about the Dog Tag Buddies program? \_\_\_\_\_

Should I be accepted into the Dog Tag Buddies Service Dog program, I, the undersigned, will be required to demonstrate aptitude, competency, and a commitment to follow Dog Tag Buddies education, standards and training. The undersigned agrees that if any of the standards of veterinary care,



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health, grooming, cleanliness, and housing are not met, or if the dog is repeatedly placed in danger or is receiving negligent care and/or treatment, Dog Tag Buddies has the absolute unequivocal right to permanently remove the dog from my possession with or without notice. The undersigned agrees that in this case no compensation and/or refund of the sponsor's placement costs will be returned.

I understand that contributions are not payment for a service dog, nor a guarantee I will receive a service dog. While contributions may be given to Dog Tag Buddies on behalf of a particular veteran, we understand those funds do not constitute a purchase. After we, the primary and secondary caregiver, have successfully completed educational training and made the required preparations to receive the service dog, Dog Tag Buddies service dog placement will proceed with the recipient and his or her family.

If at any time during the fundraising process or during team training, a Dog Tag Buddies representative determines you, a caregiver, partner or family is unsuitable to continue placement of a (service) dog, Dog Tag Buddies may exercise its right as stated above to withdraw the service dog without monetary reimbursement to any party.

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

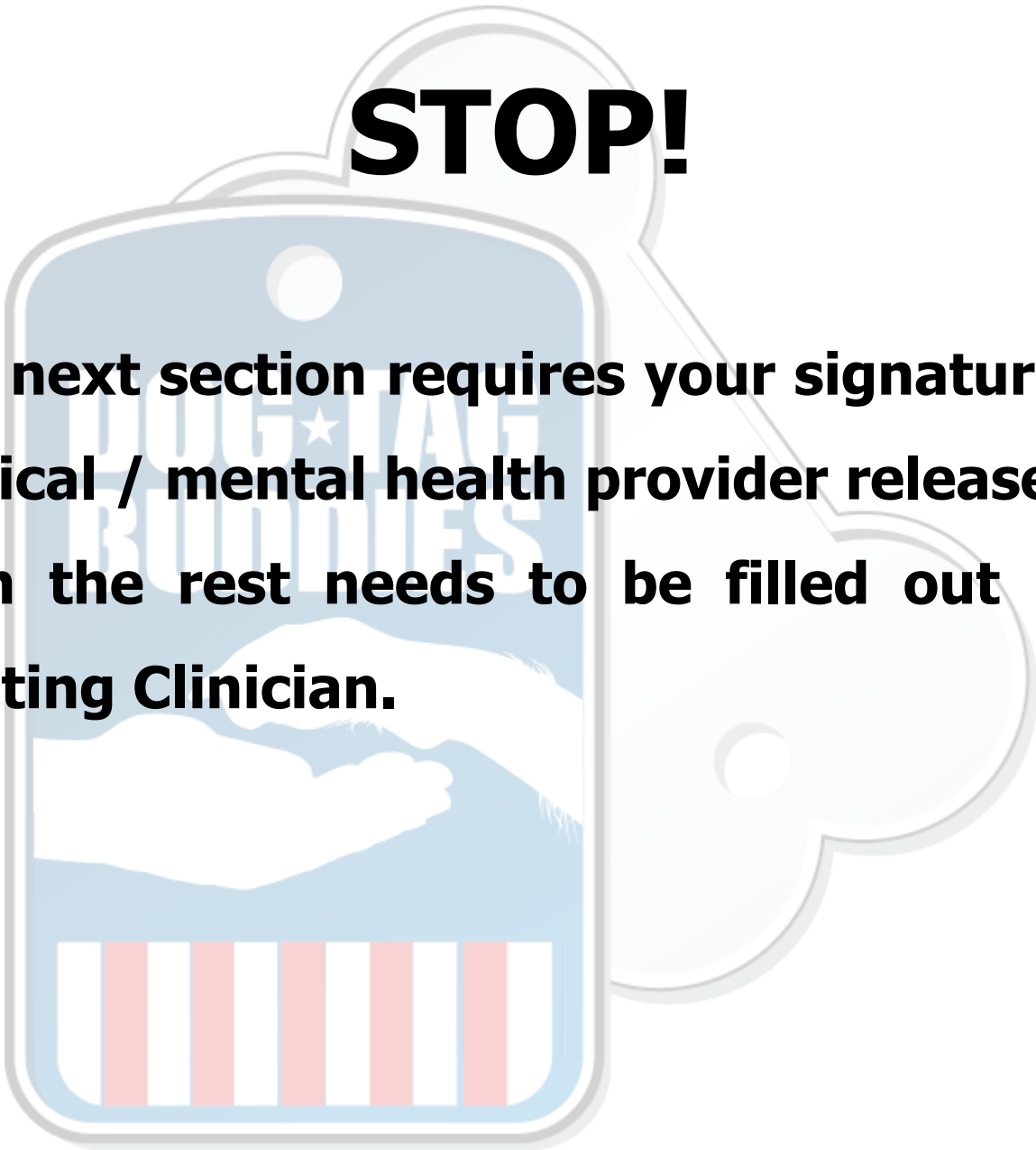
I, \_\_\_\_\_ do hereby give my permission to Dog Tag Buddies to use any comments I make and any pictures or video tapes of me, both during training and after I receive my companion or assistance dog, for publicity. This permission continues until such time as I give them written notice rescinding said permission.

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



# **STOP!**

**This next section requires your signature for medical / mental health provider release. Then the rest needs to be filled out by a Treating Clinician.**





# M E D I C A L

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## MEDICAL INFORMATION SERVICE DOG PROGRAM APPLICATION

(Must be completed by treating clinician)

### Medical/Mental Health Provider Release

Name of Provider: \_\_\_\_\_

Please release the requested medical information regarding my condition to **DOG TAG BUDDIES**. The information will be used to help the organization determine my eligibility to obtain a service dog.

Patient Name (please print): \_\_\_\_\_

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

### Medical/Mental Health Provider Contact Information

Provider name: \_\_\_\_\_

Specialty: \_\_\_\_\_

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

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

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

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

Primary diagnosis: \_\_\_\_\_

What are you treating if different from diagnosis? \_\_\_\_\_

Date of diagnosis: \_\_\_\_\_

Does diagnosis quality as a disability?      Yes      No

If yes, please explain: \_\_\_\_\_

Primary disability: \_\_\_\_\_

Secondary disability/conditions: \_\_\_\_\_

How frequently do you treat/see patient? \_\_\_\_\_



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Please list all current medications/dosage the patient is currently taking: \_\_\_\_\_

Please indicate any special instructions/considerations related to the patient's disability or medical condition.

Please rate each of the following using these number descriptions:

0 = non-applicable 1 = mild 2 = moderate 3 = severe

Motor impairments \_\_\_\_\_Weakness \_\_\_\_\_Spasticity \_\_\_\_\_Coordination \_\_\_\_\_Other

Sensory impairments \_\_\_\_\_Vision \_\_\_\_\_Hearing \_\_\_\_\_Loss of sensation

Cognitive impairments \_\_\_\_\_Attention \_\_\_\_\_Memory \_\_\_\_\_Problem solving \_\_\_\_\_Judgment

Communication impairments \_\_\_\_\_Comprehension \_\_\_\_\_Expression \_\_\_\_\_Speech

## PSYCHOLOGICAL/BEHAVIORAL DESCRIPTIONS

Please rate each of the following using these number descriptions: 0 = non-applicable 1 = mild 2 = moderate 3 = severe

\_\_\_\_\_Depression \_\_\_\_\_Impaired self-esteem \_\_\_\_\_Hopeless / Helplessness

\_\_\_\_\_Appetite disturbance \_\_\_\_\_Suicidal ideation \_\_\_\_\_Isolation/Emotionally cut off

\_\_\_\_\_Lack of empathy \_\_\_\_\_Hyper-vigilance \_\_\_\_\_Exaggerated startle response

\_\_\_\_\_Anxiety \_\_\_\_\_Panic attacks \_\_\_\_\_Difficulty relating to family/friends

\_\_\_\_\_Sleep disorder \_\_\_\_\_Nightmares \_\_\_\_\_Flashbacks

\_\_\_\_\_Insomnia \_\_\_\_\_Irritability/Anger control issues

\_\_\_\_\_Emotional numbness /Detachment/Restricted affect \_\_\_\_\_Intrusive thoughts

\_\_\_\_\_Suicide attempts \_\_\_\_\_Difficulty focusing on one thing

\_\_\_\_\_Substance abuse (alcohol/ drugs): If applicable, please describe in more detail the type and severity.

If there are other behaviors or habits that are affecting the patient negatively, please explain below.  
Is patient currently participating in treatment? If yes, explain the treatment and the patient's response.



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Has the patient received treatment in the past? If yes, please explain the nature of the treatment and the patient's response.

Has the patient participated in an in-patient or out-patient mental health program? Yes No  
If yes, please explain:

Did patient comply with treatment recommendations? Yes No

History of psychiatric, psychological/behavioral hospitalizations (include dates): \_\_\_\_\_

Date of admission	Involuntary Admit	Hospital (name and city)	Admitting problem/ Diagnosis	Discharge date
	Yes <input type="checkbox"/> No <input type="checkbox"/>			
	Yes <input type="checkbox"/> No <input type="checkbox"/>			
	Yes <input type="checkbox"/> No <input type="checkbox"/>			
	Yes <input type="checkbox"/> No <input type="checkbox"/>			
	Yes <input type="checkbox"/> No <input type="checkbox"/>			

### ADDITIONAL MEDICAL CONDITIONS (Check all that apply)

- \_\_\_\_\_ Cardiovascular disease      \_\_\_\_\_ Respiratory disease      \_\_\_\_\_ Diabetes
- \_\_\_\_\_ Seizure disorder                \_\_\_\_\_ Chronic pain                \_\_\_\_\_ Neurogenic bladder
- \_\_\_\_\_ Neurogenic bowel                \_\_\_\_\_ Other: \_\_\_\_\_

### ASSISTIVE DEVICES (Check all that apply)

- \_\_\_\_\_ Manual wheelchair      \_\_\_\_\_ Power wheelchair/scooter      \_\_\_\_\_ Walker      \_\_\_\_\_ Crutches
- \_\_\_\_\_ Cane                              \_\_\_\_\_ Orthotics                              \_\_\_\_\_ Prosthesis                              \_\_\_\_\_ Hearing aid





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Please rate (write number on the line in front of the activity) the Functional Independence Measure (FIM). Levels for the following motor activities based on this scale:

**NO HELPER**

- 7 - Complete independence (timely, safely)
- 6 - Modified independence (device)

**HELPER - MODIFIED INDEPENDENCE**

- 5 - Supervision
- 4 - Minimal assistance (can perform 75% of activity)
- 3 - Moderate assistance (can perform 50% of activity)

**HELPER - COMPLETE DEPENDENCE**

- 2 - Maximal assistance (can perform 25% of activity)
- 1 - Total assistance (can perform 0% of activity)

**Self-care:**

\_\_\_\_ Eating    \_\_\_\_ Grooming    \_\_\_\_ Bathing    \_\_\_\_ Dressing-upper body    \_\_\_\_ Dressing-lower body

**Sphincter control:**

\_\_\_\_ Bladder management    \_\_\_\_ Bowel management

**Transfers:**

\_\_\_\_ Chair, wheelchair    \_\_\_\_ Toilet    \_\_\_\_ Tub, shower Locomotion    \_\_\_\_ Walk & wheelchair  
\_\_\_\_ Walk    \_\_\_\_ Wheelchair    \_\_\_\_ Stairs

Would you recommend this individual for a service dog? Yes    No

If no, please explain: \_\_\_\_\_  
\_\_\_\_\_

Do you believe DOG TAG BUDDIES would benefit from a consultation with you to help us facilitate placement of a service dog for this patient? Yes    No

If yes, please provide a telephone number or email to initiate consultation. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you think this individual has the ability to care for a dog or implement the help necessary to care for a service dog? Yes    No

Do you think this patient requires special supervision or other supports necessary to prevent him/her from self-harm or from harming others? Yes    No

If yes, please explain. \_\_\_\_\_  
\_\_\_\_\_



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Do you believe that this patient has sufficient self-control to deal appropriately with interpersonal conflicts, disappointments and decisions that do not go his/her way? Yes No

Do you believe this patient would be responsible and compassionate with animals? Yes No

Is there anything you would like to talk to us personally about concerning this patient? Yes No

If yes, please provide a telephone number or email to initiate consultation. \_\_\_\_\_

\_\_\_\_\_

Additional comments/observations:

Provider signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please submit completed document to:

**DOG TAG BUDDIES**  
**PO Box 250**  
**Shepherd, MT 59079-0250**

# STOP!

**This next section is to be filled out by a family member NOT the applicant.**





# FAMILY

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## DOG TAG BUDDIES PROGRAM APPLICATION FAMILY QUESTIONNAIRE

(Must be completed by parent, spouse, significant other, or family member that currently lives with or sees the applicant on a weekly basis.)

All comments and responses are confidential and will not be shared with the veteran. This form is intended for Dog Tag Buddies assessment purposes only. Truthful, honest, and full disclosure is vital to a proper assessment and potential program acceptance.

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

Applicant (Veteran) Name: \_\_\_\_\_

Relationship to veteran: \_\_\_\_\_

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

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

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

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

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

### Family Questions

Do you have any concerns about the veteran obtaining a service dog? Yes No  
If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

What are the benefits you anticipate the veteran will experience as a result of a service dog?

\_\_\_\_\_  
\_\_\_\_\_

What are the benefits **you** anticipate experiencing as a result of the veteran obtaining a service dog?

\_\_\_\_\_  
\_\_\_\_\_

Are any members of the veteran's support system allergic to dogs, dog hair or dander?



# FAMILY

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Yes No

Would you like clarification or wish to speak to a **DTB** representative for additional information?

Yes No

If yes, please provide the best method to contact you.

Phone: \_\_\_\_\_

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

## Veteran's Mental/Emotional Status

Do you feel the veteran acts out in ways that are beyond his/her control? Yes No

If yes, please explain: \_\_\_\_\_

Is veteran's disability affected by drug or alcohol use or abuse? Yes No

If yes, please explain: \_\_\_\_\_

Is veteran capable of making rational decisions? Yes No

Is veteran able to communicate ideas clearly? Yes No

Is veteran able to learn and follow direction to the degree necessary to take care of a dog?

Yes No

If no, please explain: \_\_\_\_\_

Is veteran able to make rational decisions about protecting him/herself as well as the needs and safety of others? Yes No

If no, please explain: \_\_\_\_\_

Does the veteran pose a danger to him/herself or others? Yes No

If yes, please explain: \_\_\_\_\_

Does the veteran exhibit awareness of surroundings? Yes No

Is the veteran able to maintain an attention span long enough to complete tasks or conversations?

Yes No

Is the veteran oriented to time, place and persons? Yes No



# FAMILY

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Is the veteran able to relate positively to others?    Yes    No

Does the veteran act out inappropriately when frustrated or angry?    Yes    No

If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

Is the veteran able to form insights, judgments and plan a course of action?    Yes    No

If no, please explain: \_\_\_\_\_  
\_\_\_\_\_

Please provide any other information you feel will be relevant in assisting the veteran.

\_\_\_\_\_  
\_\_\_\_\_

Thank you for taking the time to complete this questionnaire. If the veteran is accepted, we look forward to working with you as a helpful contributor in this process.

Please submit this document electronically to [director@dogtagbuddies.org](mailto:director@dogtagbuddies.org) or by mail to

**Dog Tag Buddies**

**PO Box 250**

**Shepherd, MT 59079**