**PLEASE MAKE YOUR APPOINTMENT BEFORE APPLYING FOR THE VOUCHER**

**Harrison County Residents Only**

**MUST SEND PROOF OF INCOME** Federal or State Tax Return with SSN Blacked out - if do not file taxes need IRS determination letter stating that as well as copies of W2s or SSI or DHHR statement of monthly benefits. You can get proof of benefits from SS or DHHR office.

NO BANK STATEMENTS, NO PAY STUBS.

Must have proof for all incomes in the household.

SEND A **SELF ADDRESSED STAMPED ENVELOPE** FOR US TO RETURN THE VOUCHER.

Mail to: P.O. Box 4397 Clarksburg, WV 26302 or Drop off to: 2450 Saltwell Road Shinnston, WV 26431

Have questions? Call: (304) 592-1600 Fax: 304-592-2391 or Email: info@hshcwv.org

**BOTH PAGES OF THE APPLICATION NEED COMPLETED.**

VOUCHERS MISSING ANY INFORMATION OR INCOME PROOF WILL **NOT** BE PROCESSED.

Each voucher is only good for 60 days. Only 4 vouchers per family per twelve month period.

There will be no reissues. This is why it’s important to have appointment made before receiving voucher.

Household income guidelines:

$28,000 – individual $32,000 – 2 persons $36,000 – 3 persons $40,000- 4+ persons

**Application for Low Income Spay/Neuter & Immunization**

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

Address (including city/state/zip): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Total Household’s Yearly Income:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Circle: Married / Single

# of people in the Household: \_\_\_\_\_\_ # Of dependents claimed/children in house: \_\_\_\_\_\_\_\_

**PET INFORMATION**

**PLEASE DO NOT APPLY IF YOUR ANIMAL IS UNDER 5 MONTHS OLD**

**VETERINARIANS IN THIS AREA WILL NOT SPAY/NEUTER UNDER 5 MONTHS OLD**

Age \_\_\_\_\_\_\_\_ Weight \_\_\_\_\_\_\_\_ Pet’s name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Circle: Dog / Cat Male / Female Breed / Color \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FINANCIAL INFORMATION**

What is your current yearly net (take-home) income from all sources?

|  |  |
| --- | --- |
| Employer(s) $ | Second job $ |
| Self Employment $ | Food stamps $ |
| Public Assistance $ | Disability $ |
| SSI / Soc Sec $ | Unemployment $ |
| Alimony $ | Pension $ |
| Child Support $ | Other $ |

**Yearly HOUSEHOLD Total**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (if your income is $0, SSI or DHHR statement of monthly benefits will provide this)

# Of Pets in the home: \_\_\_\_\_ Are others spayed/neutered (if not – why?) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Where did you get your pet? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason for assistance? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FOR ADDITIONAL PETS, PLEASE OBTAIN ANOTHER FORM**

**Please choose one of the participating veterinarians listed below (check in box):**

|  |  |  |  |
| --- | --- | --- | --- |
| All Pets  (304) 624-5311 | Animal Medical Ctr (304) 292-0126 | Audubon Animal Clinic (304) 842-4836 | BrookValley Vet  (304) 296-2916 |
| Cheat Lake  (304) 594-1124 | Clarksburg Vet  (304) 623-3545 | Fairmont Vet  (304) 363-0930 | Grace Animal Hosp (304) 848-2420 |
| Grafton Vet  (304) 265-4850 | **Harrison Central \***  (304) 624-9305 | Hickman Run  (304) 333-6365 | Mannington Vet  (304) 825-1145 |
| Middletown  (304) 366-6130 | Mountaineer Vet  (304) 296-1667 | Good Hope\*  (304) 745-3870 | Upshur Vet  (304) 472-6575 |
| Weston  (304) 269-3288 | Mountain State Vet  (304) 825-1145 |  |  |

\***Existing clients only**

By signing my name on this form, I swear to or affirm (1) the completeness and truthfulness, to the best of my knowledge, of the information I have provided, and (2) my belief that I qualify for assistance through the Humane Society of Harrison County, Inc. to assume the cost of having my pet spayed/neutered at a reduced rate. I do not hold   
the Humane Society of Harrison County responsible in any way regarding the medical treatment received as a participant in the spay/neuter immunization program

Signature of Applicant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

Signature of HSHC Representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Approval: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (must be used within 60 days of this date)