The Joys of Living Assistance Dogs

Owner Trained Program

Application Checklist

___ $100 Application Fee

___ Part A - Applicant Information

___ Part B – Disability Information

___ Part C – Assistance Dog Agreement

___ Two Letters of Recommendation

___ Part D - Medical Form

JLAD will keep your entire application confidential.

APPLICATION PART A

Applicant Information

Date: _____

First Name: _____ MI: ____ Last Name: _____

Address: _____
Street City State Zip

Home Phone: _____ Cell Phone: _____

E-mail: _____

Emergency Contact:

Name: _____ Relationship: _____

Address: _____
Street City State Zip

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: _____

Phone: _____

How did you learn about JLAD?

_____

_____

_____

_____

Please select from the following list the type of dog that would be best for your current situation**:**

Service Dog: ____

A service dog is trained to perform task(s) for a person with a disability. The dog is granted full public access.

Home Help Mate: _____

A home help mate is trained in basic obedience skills and some custom tasks to assist a client with a disability. The dog is not granted public access and is trained to assist the client only in the home.

What are your expectations of your dog?

_____

_____

_____

_____

_____

_____

APPLICATION PART B

Disability Information

What is your disability?

_____

_____

_____

_____

_____

Do you have any other diagnosis, including mental health diagnosis?

_____

_____

_____

_____

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

_____

_____

_____

_____

Please indicate the devices 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 strengths and abilities. (On a scale of **1=No Use** to **10=Full Use**)

	Left	**Right**
Hand Strength		
Dexterity		
Arm Strength		
Upper-Body Strength		
Leg Strength		
Leg Control		

Do you fall and if yes how often?

_____

_____

_____

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 ____ Digital Recording ____ Note taker ____

Your Learning Ability ____

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

How do you handle the following, cont.

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.

_____

_____

_____

_____

_____

Do you work or attend school? ____Yes ____ No ____

If you work or attend school 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.

_____

_____

_____

What pets do you have now? Describe type and age.

_____

_____

_____

Veterinarian's name and phone number.

_____

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

_____

_____

_____

Will it be difficult for you?

- To attend team training classes at the JLAD Training Center in Salem, Oregon for five hours a day for 2 weeks? ___Yes ___ No.
- Will you require an attendant to assist you during these two weeks of training?

  ___Yes ___ No.

Please explain any Yes answer:

_____

_____

_____

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 Joys of Living Assistance Dogs.

Please send letters of recommendation to:

Joys of Living Assistance Dogs, Inc.
PO Box 12023
Salem, Or 97309
info@joydogs.org

APPLICATION PART C

Assistance Dog Agreement

Living with an Assistance Dog

To continue to have a functional working dog it is important that you consistently adhere to the following conditions:

1. Your dog will spend most of their time with you at home AND at work, at school, and social events if he/she is certified for public access and will not be left alone for long periods of time.

2. Your assistance dog is not a family pet – he or she has a specific function in their partner's life and must maintain minimal interaction with others including family members and friends.

Requirements of a dog trained by JLAD

1. You and your dog are ambassadors for The Joys of Living Assistance Dogs, 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, manners and behavioral expectations, as well as your handling skills.

2. When your dog is in coat in public the dog will be kept on leash.

3. You will maintain appropriate training and behavior of your dog, and will renew your ADI public access certification every two years. You must maintain identification for public access, if applicable.

4. You will clean up after your dog eliminates in public and for will repair any damage caused by your dog.

Your signature below signifies that you agree to the conditions listed above and the requirements set forth above.

Signature of Applicant_____Date_____

Mail to application to : **Joys of Living Assistance Dogs**
PO Box 12023
Salem, Or 97309

Client Application Part D
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.

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): _____

_____

How severe is the patient's mobility impairment? (Please circle)

None		Needs assistive device		Needs full-time care
___1	___2	___3	___4	___5

How severe is the patient's visual impairment? (JLAD does not train dogs to assist visual impairment.)

None/correctible with glasses		Needs assistive device		Blind
___1	___2	___3	___4	___5

How severe is the patient's auditory impairment? (JLAD does not train dogs to assist auditory impairment.)

None		Needs assistive device		Deaf
___1	___2	___3	___4	___5

How severe is the patient's cognitive impairment?

None		Often needs assistance		Needs full-time care
___1	___2	___3	___4	___5

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

Normal		Moderate		Poor self-control
___1	___2	___3	___4	___5

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

Ineffective		Moderate		Very competent
___1	___2	___3	___4	___5

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

Unreliable		Moderate		Very reliable
___1	___2	___3	___4	___5

To what degree do limitations affect patient's ability to perform Activities of Daily Living* (ADL):

Normal		Moderate		Totally reliant
___1	___2	___3	___4	___5

* 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:

	Yes	**Minimally**	**No**
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? _____

Has permanent damage resulted? ____Yes ____ No

Has patient refused treatment or referral to a treatment center? ____Yes ____ No

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

Manners and obedience	Enhance balance while walking
Retrieve dropped articles	Enhance balance while going up or down stairs
Push Lifeline or 911 button	Provide brace for transfers or getting up from floor/chair
Find and retrieve phone	Assist in pulling wheelchair
Find help	Retrieve adaptive equipment
Retrieve from refrigerator	Carry items in mouth or backpacks
Push handicap buttons	Take items to another person
Turn lights off and on	Specialized tasks as needed by client; e.g., assist with laundry, get
Open and close doors	the mail, tug shoes or coat off

Our dogs' job is to provide assistance with a variety of tasks and companionship. Are there other ways in which you think your patient would benefit from receiving a JLAD dog? If so, please describe:

_____

_____

_____

Can you recommend that this patient receive a JLAD 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: **Joys of Living Assistance Dogs**

PO Box 12023

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