



Animal Health Center

New Client Application

Your Name: _____ Today's Date: _____

Address: _____ Apt. #: _____

City: _____ State: _____ Zip Code: _____

Phone Number (Cell): _____ (Home): _____

Email: _____

Pet's Name(s): _____

Specie(s): Dog ___ Cat ___ Rabbit ___ Sex: _____ Spayed/Neutered? _____

Age of Pet(s): _____ Breed(s): _____ Color(s): _____

Previous Veterinarian: _____

Reason for Visit: _____

Application for Financial Assistance:

Do you currently receive (check all that apply):

Medicaid / Medicare

WIC / EBT / Food Stamps

Rite Care

SSDI / SSI

Subsidized Childcare

TDI

Heating Assistance

Subsidized Housing

Number of Persons in your Household: _____ Annual Household Income? _____

For one person household, is your income greater than \$21,900? Yes _____ No _____

I certify that all answers to the questions are true and complete to the best of my knowledge, and I understand that if my financial information is misrepresented, I am liable for full repayment of all discounted fees. I understand full payment must be made at the time services are performed. I assume financial responsibility for all charges incurred and agree to pay 100% of the balance of my invoice at the time of checkout. To continue receiving discounted services, all pets must be spayed or neutered within six (6) months of your first appointment. Failure to comply with this policy will automatically disqualify you from receiving discounted services at the Rhode Island SPCA Animal Health Center until your pet is spayed or neutered. Please type your full name below.

Signature of Applicant: _____