TAKE THE LEAD APPLICATION FOR ASSISTANCE

NAME _____

STREET ADDRESS_____

CITY_____ STATE_____ ZIP_____COUNTY_____

PHONE (Cell)_____ (Home)_____ (Fox)_____

E-MAIL ADDRESS_____

SOCIAL SECURITY NUMBER_____ DATE OF BIRTH_____

INVOLVEMENT IN THE SPORT OF DOGS

Currently own AKC REGISTERED DOG? Yes_____ No_____ If yes, how many live with you? _____

Which breeds? _____

Currently active in what area of the sport? _____ Number of years_____

If not active, please state the reason. _____

What has been your involvement in the sport of dogs. Please describe.

_____

Are you now, or have you ever been a member of an AKC licensed Kennel Club? Yes____ No_____

If Yes, name(s) of Kennel Club(s):_____

_____

REFERENCES: List names, State of residence, e-mail address and phone number of two contacts in the sport, (club member, judge, handler, superintendent, etc.). **Please indicate your most frequently used Superintendent as one of your references.** References may be contacted to verify participation in AKC events.

1._____

_____

2_____

_____

DESCRIBE MEDICAL/EMERGENCY SITUATION IN DETAIL

_____

_____

_____

_____

IMPORTANT! A CURRENT LETTER FROM YOUR PHYSICIAN, WHICH INCLUDES DIAGNOSIS, PROGNOSIS AND TREATMENT PLAN, MUST ACCOMPANY THIS APPLICATION FOR MEDICAL ASSISTANCE

HEALTH INSURANCE INFORMATION/MEDICAL CARE COVERAGE FOR MEDICAL ASSISTANCE ONLY

Medicare number: _____

Medicaid number: _____ Have you applied? Yes____ No_____

If Medicaid is pending, what is the status? Approved___ Pending ____ Denied _____

HEALTH INSURANCE? Yes __No __ Employer insured: Yes __ No __ Self Insured: Yes __ No___

Other Health Insurance: Yes___ No ___

If YES for any of the above, please list insurance provider, address & phone:_____

_____

Subscriber's Name: _____

Group Policy # (if applicable) _____ Your Policy ID#_____

EMPLOYMENT STATUS: Full Time____ (35+ hrs/wk) Part Time____ (Less than 35 hrs/wk) Medically unable to work _____

Retired _____ Not disabled and not employed _____

FINANCIAL STATUS - Total Assets (please complete the following):

Present annual gross income: _____ Salary/wages: Self _____ Spouse/Partner:_____ Other household members _____ Other Income _____

Benefits: (i.e., Public Assistance, Unemployment, Social Security): _____

Checking/savings/investment account balances: _____

Retirement income Accounts: _____ Trust Fund: _____

Value of real property _____

Vehicles: _____

Other Assets: _____

Do you have a "Go Fund Me" Account? Yes ___ No ___ If yes, list balance _____

A COPY OF LAST YEAR'S TAX RETURN MUST ACCOMPANY THE APPLICATION

Living Arrangements (monthly):

Own? ____ Mortgage _____ Taxes _____ Rent? _____ Amount _____

Monthly Utility Costs? _____

How can we help you:

Take the Lead provides assistance by making direct payments to providers for services. (Example: medications, insurance premiums, utilities, rent, and other related services). Please be specific as to what you are asking Take the Lead to help you with. Be certain to list the name of the provider and include cost of services on a monthly basis.

_____

_____

_____

_____

_____

_____

Household Members: **NAME** **RELATIONSHIP**

_____ _____

_____ _____

_____ _____

I, _____ hereby authorize you to furnish TAKE THE LEAD representatives, any and all records of any kind pertaining to me, including but not limited to, my medical history, medical or other services rendered, treatment billings, and all such related records. This authorization shall become effective immediately and shall remain in full force and effect as long as necessary.

I understand that some restrictions for receipt of, or release of medical information may apply to TAKE THE LEAD in reference to some medical or other facilities. I hereby direct that no further authorization other than what is specifically indicated in this form to be required and/or requested of TAKE THE LEAD. The federal privacy act and other applicable governmental regulations have increased the need for security in the transfer of privileged communications, and the information to be released will be from records, the confidentiality of which, is protected by those regulations, and prohibits anyone from making any further disclosure of such information without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A photocopy of this signed authorization shall be deemed as valid as an original

I have read the above and fully understand its content in its entirety and have asked questions about everything that was not clear to me and am satisfied with the answers I have received.

***If for any reason your financial circumstances change, you agree to notify us immediately, as that may affect our level of support.**

ALTERNATE CONTACT: I AUTHORIZE TAKE THE LEAD TO SPEAK WITH THE FOLLOWING PERSON(S) ABOUT MY APPLICATION, IF YOU ARE UNABLE TO CONTACT ME (i.e., Social worker, lawyer, family, or friend).

NAME_____ RELATIONSHIP_____

PHONE: _____ E-MAIL: _____