St. Augustine Humane Society
info@staughumane.org
tel. 904.829.2737 fax. 904-824.8817
email: info@staughumane.org
www.staugustinehumanesociety.org

Benefits Qualifying Application

Date: _____ Referred by:_____

Pet Owner's Name_____ Home Phone_____

Work or Cell Phone_____ Email_____

Address_____

City_____County_____ST_____Zip_____

Program under which you are claiming qualification: (Proof of program or income must be attached)

_____Medicaid
_____Food Stamps
_____WIC
_____MediPass
_____MediKids
_____KidCare
_____Section 8, Public Housing
_____SSI (Supplemental Security Income – NOT Social Security)
_____Wildflower Project

Program Number_____ Other_____

Or, if you are not on one of the above programs, give income information for your household:

persons living in household:_____ Total Gross (before taxes) Monthly Household Income _____

Number of Pets: ____Cats ____Dogs ____Rabbit s ____Birds ____Other_____

Description of Benefit Need:_____

Waiver of Liability

1. The above described pets live at my home address.
2. I attest that the above information is true and correct to the best of my knowledge

Signature of Pet Owner_____ Date _____

Office Use Only: Application is _____approved _____denied

Date Reviewed_____ Surgery Scheduled for _____

Notes:_____

SAHS Representative_____