

Drop off, mail, e-mail, or fax this form to:

Kauai Humane Society
Attn: Executive Director
P.O. Box 3330
Lihue, HI 96766



**Spay/Neuter Assistance Program
Application**

snclinic@kauaihumane.org

Owner Name: _____ **Date:** _____

Address: _____

City: _____ **ZIP Code:** _____

Home Phone: _____ **Cell Phone:** _____

Employer: _____ **Phone:** _____

Are you currently receiving any city or government financial assistance? **Yes / No** Type _____

Total household monthly income \$ _____ **If yes, what is the monthly amount?** \$ _____

Number of dependents in household (exclude yourself) _____

Ages of all dependents _____

LIST ALL CURRENT ANIMALS IN HOUSEHOLD

DOGS:

					<u>Altered?</u>
Name _____	Sex _____	Breed _____	Weight _____	Age _____	Yes / No
Name _____	Sex _____	Breed _____	Weight _____	Age _____	Yes / No
Name _____	Sex _____	Breed _____	Weight _____	Age _____	Yes / No
Name _____	Sex _____	Breed _____	Weight _____	Age _____	Yes / No

CATS:

Name _____	Sex _____	Breed _____	Weight _____	Age _____	Yes / No
Name _____	Sex _____	Breed _____	Weight _____	Age _____	Yes / No
Name _____	Sex _____	Breed _____	Weight _____	Age _____	Yes / No
Name _____	Sex _____	Breed _____	Weight _____	Age _____	Yes / No

Do you have a regular vet? **Yes /** **No** If yes, who _____

Clinic _____ Phone _____

Are your animals currently vaccinated? **Yes / No**

FOR OFFICE USE

Date contacted _____ **By** _____

Date of surgery _____

Amount paid for surgery _____

Participation Amount _____

Amount to charge program _____

Staff Initials _____