



## APPLICATION FOR BUDDY'S FUND ASSISTANCE

Date of Application \_\_\_\_\_

Name of Applicant \_\_\_\_\_

Street \_\_\_\_\_

City \_\_\_\_\_ State / Zip \_\_\_\_\_

Phone \_\_\_\_\_ Email \_\_\_\_\_

May we contact you to further support the Buddy-CARE Fund cause? Y / N

Species: Dog Cat Bird Bunny Horse Exotic  
Stray / Unknown

Companion Animal Name \_\_\_\_\_

### Notes

- Subject to funds availability
- Family combined income cannot exceed \$50,000 in order to be eligible for Buddy's Fund Assistance
- Income statements (Form 1040 or equivalent) must be attached to this form in order for the participating veterinary hospital to be reimbursed. Social Security numbers may be removed.
- Fund limited to one incident of assistance per household.
- Upon request, applicant can demonstrate safe and secure environment where companion animal will reside.

I certify that the information supplied with this application is correct and true to the best of my knowledge and belief. Further, I understand that any false information will void this request and make me solely responsible for all the veterinary and hospital charges incurred while treating the above described companion animal.

I give my permission to post my story and/or photos for purposes including, but not limited to organizational promotion, advertising and fundraising.

Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

Applicant must provide the Buddy Fund with all of the following to receive any financial assistance:

- The original "Application for Buddy Fund Assistance" (Applicants should keep a copy for their records.)
- A copy of prior year IRS Form 1040, or equivalent, or other documentation acceptable to establish need.
- A copy of the actual hospital bill, showing Applicant paid at least 20% of the estimate.



### FORMULA FOR BUDDY'S FUND ASSISTANCE

| COLUMN   | DESCRIPTION   | AMOUNT | CERTIFICATIONS |                            |
|----------|---|--------|----------------|----------------------------|
| <b>A</b> | Estimate of hospital charges  | \$     |                |                            |
| <b>B</b> | Applicant pays 20% (min) as deposit   | \$     | _____          | Applicants initials        |
| <b>C</b> | Hospital determines actual charges  | \$     |                |                            |
| <b>D</b> | Hospital discounts by 15%   | \$     |                |                            |
| <b>E</b> | Hospital net actual charge  | \$     |                |                            |
| <b>F</b> | Less applicant deposit  | \$     |                |                            |
| <b>G</b> | Buddy's fund assistance amount  | \$     |                |                            |
| <b>H</b> | Applicants remaining balance  | \$     | _____          | Applicants initials        |
| <b>I</b> | Hosp has "request" form, income eligibility, and certifies that applicant meets fund guidelines | \$     | _____          | Hospital employee Initials |

**Office Use Only:**