



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
- Maximum award per applicant is \$1,000 - after applicant has paid at least 20% of estimate. If bill exceeds estimate, pet guardian remains responsible for the minimum 20% of total cost.
- 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	
A	Estimate of hospital charges	\$		
B	Applicant pays 20% (min) as deposit	\$	_____	Applicants initials
C	Hospital determines actual charges	\$		
D	Hospital discounts by 15%	\$		
E	Hospital net actual charge	\$		
F	Less applicant deposit	\$		
G	Buddy's fund assistance amount	\$		
H	Applicants remaining balance	\$	_____	Applicants initials
I	Hosp has "request" form, income eligibility, and certifies that applicant meets fund guidelines	\$	_____	Hospital employee Initials

Office Use Only: