

# FACE Request for Financial Assistance

Owner Name(s)	Home Address <input type="checkbox"/> own <input type="checkbox"/> rent	Mailing Address	Telephone
Owner E-Mail	Employer's Name	Employer Address	Telephone
Pet's Name	Referring Vet/Hospital	Vet/Hospital Address	Telephone
Breed <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> N	Ownership Duration	Pet Med Insurance <input type="checkbox"/> Y <input type="checkbox"/> N	
Vaccines Current <input type="checkbox"/> Y <input type="checkbox"/> N	Birth Date	If Yes, Company/Policy No.	
Number of Pets	Prior FACE Funds <input type="checkbox"/> Y <input type="checkbox"/> N	If Yes, Amount and Date	
Annual Household Income	Nature of Financial Hardship	Referred to FACE by	

I declare that I have exhausted all alternative options available to me for immediate financial assistance, however, I agree to reimburse the Foundation for any funds received upon a change in my financial circumstances. In addition, I hereby assign to the Foundation all rights to any amounts received from insurance or other source of recovery related to this matter. I do not operate any form of breeding facility for profit and agree to provide a copy of my 1040 tax return in support of this request.

I understand that the FACE Foundation is not responsible for the treatment and/or result of any veterinary services provided and hereby waive any and all claims for liability against the Foundation, and that the Foundation hereby reserves the right to deny a Request for Financial Assistance to anyone for any reason. I also authorize the Foundation to use my photograph and/or my pet's photograph and any information relating to the payment of funds pursuant to this Application for any purpose.

I declare, under penalty of perjury, that the foregoing is true and correct to the best of my knowledge.

Date	Owner Signature	Owner Signature
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Treating Veterinarian	Address	Telephone	\$ Treatment Estimate [inc f/u, meds, etc]
Diagnosis Summary	Prognosis <input type="checkbox"/> G <input type="checkbox"/> F <input type="checkbox"/> P	Recommended Procedure	
I agree to a 25% discount from the usual and customary rate for treatment to be funded by this grant, if approved.			
Date	Signature	Hospital	EIN/Tax ID

\$ 25% Discount	\$ Approved Credit <input type="checkbox"/> Y <input type="checkbox"/> N	\$ Owner Contribution	\$ FACE Funds
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REQUEST <input type="checkbox"/> APPROVED	DATE	BY	FACE ACCT ID
<input type="checkbox"/> DENIED	DOCUMENTS ATTACHED →	<input type="checkbox"/> CREDIT APPLICATION RESULTS <input type="checkbox"/> DIAGNOSIS, PROGNOSIS AND TREATMENT <input type="checkbox"/> ESTIMATE FOR TREATMENT <input type="checkbox"/> MEDICAL RECORDS/HISTORY <input type="checkbox"/> CURRENT 1040 TAX RETURN	

