

Rhode Island Veterinary Medical Association
Companion Animal Foundation
Request for Veterinary Medical Assistance

Please complete this form in full. Submission does not guarantee that you will be eligible for veterinary medical assistance from the RIVMA Companion Animal Foundation. Your pet must live with you and that legal residence must be in Rhode Island to qualify.

Please print

Your name _____ Today's date _____
Address _____ Apt. # _____
City, State, Zip _____
Telephone number (day) _____ (evening) _____
E-Mail _____

Your pet's name _____
Species (circle one): Dog Cat Bird Ferret Other:

Age _____
Length of time you have owned your pet _____

Name of Clinic/Hospital where treatment will be provided:

Name of your regular veterinarian:

Your financial information

Are you currently employed? ____ Yes ____ No
Do you currently received(check all that apply):

- ____ Medicaid
- ____ RiteCare
- ____ Food stamps
- ____ Subsidized child care
- ____ Subsidized housing
- ____ WIC
- ____ Family Independence Program
- ____ SSI
- ____ Heating Assistance

Is your annual household income, for one person, more than \$9,310? ____ Yes
____ No

I certify that all answers to these questions are true and complete to the best of my knowledge and I understand that if my financial information is misrepresented, I am liable for full repayment to the RIVMA Companion Animal Foundation of any assistance funds received.

Signature of applicant

Veterinarian information

Veterinarian's name: _____
Clinic/Hospital name: _____

Are you a current RIVMA member? Yes No

Amount requested for assistance: _____

Treatment provided: _____

Total cost of treatment: _____

Date treatment provided: _____

Other comments:

Veterinarian's signature

Date submitted

PLEASE RETURN A SIGNED ORIGINAL COPY OF THIS FORM TO:

Via fax: 1.866.882.7039

Via mail:

RIVMA Companion Animal Foundation
11 South Angell Street, # 311
Providence, RI 02906