K9 Healing Warriors

Service Dog Program

for wounded warriors

Intake Packet

www.heartbeatforwarriors.org

(425)931-1047
Heartbeat Serving Wounded Warriors®
PO Box 610
Onalaska, WA 98570

Dear Veteran,

Welcome to K9 Healing Warriors.

Thank you for your courage in serving our country. You are the plumb line of excellence for this country!!

Thank you for your interest in our Owner Train Service Dog Program, K9 Healing Warriors. It is an honor to hopefully serve you with this program. Our commitment to your complete success with this program is 100%. I realize the intake packet is long, but it allows us a way to serve you and your dog better or, if need be, to assist in finding a dog for you.

Heartbeat Serving Wounded Warriors®, K9 Healing Warriors program will be responsible for paying all training and equipment fees for this program. We work with Cascade Service Dogs in Olympia WA, who provides outstanding training in this Service Dog program. This program is unique in that we train the Warrior and his/her own dog that he/she has already established a relationship with.

Please feel free to contact me with any questions prior to completing this intake packet.

A COMPLETED INTAKE PACKET INCLUDES:

1) **THE INTAKE PACKET, FILLED OUT AND SIGNED.**
2) **A PROFESSIONAL LETTER OF REFERENCE FROM A THERAPIST, SOCIAL WORKER, COUNSELOR, PHYSICIAN, PSYCHOLOGIST, OR PSYCHIATRIST STATING A SERVICE DOG WOULD PROVIDE A BENEFIT TO YOU AND YOUR DAILY LIVING WITH REGARD PTSD, TBI AND/OR PHYSICAL INJURIES.**
3) **A COPY OF YOUR DD-214.**
4) **A COPY OF MILITARY MEDICAL BOARD OR A VA RATING LETTER CONFIRMING INJURIES.**
5) **<u>THREE</u> REFERENCE LETTERS (FROM FRIENDS, RELATIVES, BOSS, ETC.) REGARDING HOW THEY SEE A TRAINED SERVICE DOG WOULD BENEFIT THE WARRIOR.**
6) **VETERAN MUST HAVE BEEN INJURED/WOUNDED DURING COMBAT DEPLOYMENT DURING GWOT TO INCLUDE FIRST GULF WAR, OIF, OEF.**

VETERAN AGREES TO:

1) Bring his/her dog, no older than four (4) year of age, to be evaluated for your training by Sharon at Cascade Service Dogs.

2) Dog must be spayed or neutered by one (1) year of age, current on vaccinations and exam, and provide a copy.

3) Team (Veteran and dog) will train 180-300 hours for 9-12 months, as determined by the Team's progress.

4) Team will attend a minimum of two 1-hour training classes per week.

5) Team will practice 1-2 hours a day on their own with instructions given during class.

By signing below, you agree to the above.

_____ _____

Name Date

Heartbeat Serving Wounded Warriors®

Contact Information

K9 Healing Warriors

Janice Buckley, President

Janice@heartbeatforwarriors.org

(425)931-1047

Warriors Personal Data Sheet

GENERAL INFORMATION Date: _____

Name: _____ Rank/Grade: _____

Branch of Military:

☐USAF ☐USN ☐USA ☐USMC ☐USCG

☐Active Duty ☐Reserve ☐Guard ☐IRR ☐ Retired

MOS when deployed: _____ Date of Birth (MM/DD/YYYY): _____

Age: _____ Weight (lbs): _____ Height: ___ Feet: ___ Inches Blood Type: _____

Local Address: _____ City: _____ State: ____ Zip:_____

Email: _____ Phone No: _____ ☐Cell ☐Home ☐Work ☐Message

☐ Permanent address is same as local address

Permanent Address: _____ City: _____ State: _____

Zip: _____ Phone No: _____ ☐Cell ☐Home ☐Work ☐Message

DEPENDENTS

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated

Spouses Name: _____

Children: Number: _____ Ages: _____

IN CASE OF EMERGENCY

Name: _____

Address: _____ City: _____ State: _____

Zip: _____ Phone No: _____ ☐Cell ☐Home ☐Work ☐Message

Describe the obstacles/challenges you encounter at home and in the community:

_____

_____

Are you anticipating a life change in the next year? □ Yes □ No

If yes, please describe:

_____

_____

Do you live in a □ House □ Apartment □ Other

Do you anticipating a move within the next year? □ Yes □ No

SERVICE DOG INFORMATION

Have you ever had a service dog? □ Yes □ No

Describe the accommodations for your dog at home and work, if you are employed:

_____

_____

Describe your fenced yard:

□ 4 foot wood fence □ 6 food wood fence □ No fence
□ 4 foot chain link fence □ 6 food chain link fence □ Other: _____

Is your yard completely fenced? □ Yes □ No

What is your current means of support? _____

Current annual income:

□ Less than $10,000 □ $10,000 - $20,000 □ $20,000 - $30,000 □ $30,000 - $40,000
□ $40,000 - $50,000 □ $50,000 - $60,000 □ $60,000 - $70,000 □ $70,000 - $100,000

Can you support the cost of a service dog's food and health care?
(between $700-$1,000 per year) □ Yes □ No

How many hours a day will your service dog be alone? _____
Please explain: _____

Do you plan to take your service dog to work with you? □ Yes □ No

If yes, have you already discussed this with your employer? □ Yes □ No

Does your employer have any concerns about you bringing your service dog with you? □ Yes □ No

Please describe what your employer is concerned about: _____

_____

Are you able to perform everyday tasks such as:

Feeding yourself? □ Yes □ No

Dressing yourself? □ Yes □ No

Personal hygiene? □ Yes □ No

Maintain your own residence? □ Yes □ No

Manage your own finances? □ Yes □ No

Utilize outside services? □ Yes □ No

If you answered no to any of the above tasks, who does these things for you? _____

_____

Are you, or is anyone you live with, allergic to dogs? □ Yes □ No

If yes, to what extent? _____

_____

Do you have any animals **in your home** at this time? □ Yes □ No

Please list all animals (name, age, type of animal, etc. _____

_____

Do you have any outdoor animals? □ Yes □ No How many? _____

What kind? _____

Medical History Form

GENERAL INFORMATION

Name _____ Date of birth (MM/DD/YYYY) _____

Age _____ □Male □Female

Address _____ City _____ State_____

Zip _____ Phone No. _____ □Cell □Home □Work □Message

HEALTH / ACCIDENT INSURANCE COMPANY

□DAN □TRICARE □VA □Other (specify): _____

Primary Sponsor Name: _____ Policy No. _____

HEALTH HISTORY

Please fill in the bubbles as indicated below:

Do you currently have, or have you ever been treated for any of the following?:

Yes	No	Condition/Injury	Explain
□	□	**Asthma** Last attack: (MM/YY) □□ / □□	
□	□	**Diabetes** Last HbA1c: (%) □□□. □□**%**	
□	□	**Hypertension** (high blood pressure)	
□	□	**Heart disease/heart attack/chest pain/heart murmur**	
□	□	**Stroke/TIA**	
□	□	**Lung/respiratory disease**	
□	□	**Ear/sinus problems**	
□	□	**Muscular/skeletal condition**	
□	□	**Menstrual problems (women only)**	
□	□	**Psychiatric/psychological**	
□	□	**Behavioral/neurological disorders**	
□	□	**Bleeding disorders**	
□	□	**Fainting spells**	
□	□	**Thyroid disease**	
□	□	**Kidney disease**	
□	□	**TBI/Migraines/Headaches**	
		How injured:	
□	□	**Sickle cell disease**	
□	□	**Seizures** Last seizure: (MM/YY) □□ / □□	
□	□	**Sleep disorders** (e.g., sleep apnea)	Use CPAP: □Yes □No
□	□	**Abdominal/digestive problems**	
□	□	**Surgery** Last surgery: (MM/YY) □□ / □□	
□	□	**Serious injury**	
□	□	**Excessive fatigue or shortness of breath w/ exercise**	
□	□	**Other**	

HEALTH HISTORY (*continued*)

Loss of arm strength: (Please check the level that you are generally at each day)

Right arm: ☐ Mild loss ☐ Moderate loss ☐ Severe loss ☐ No loss

Left arm: ☐ Mild loss ☐ Moderate loss ☐ Severe loss ☐ No loss

Loss of fine motor skills in your hands:

Right hand: ☐ Mild loss ☐ Moderate loss ☐ Severe loss ☐ No loss

Left hand: ☐ Mild loss ☐ Moderate loss ☐ Severe loss ☐ No loss

Do you have any vision loss that can NOT be corrected with glasses? ☐ Yes ☐ No
If yes, please explain: _____

Reaction Speed: ☐ Normal ☐ Slightly impaired ☐ Moderately impaired ☐ Severely impaired

Endurance: ☐ High ☐ No limitations ☐ Moderate ☐ Mild

Balance: ☐ Normal ☐ Mildly impaired ☐ Moderately impaired ☐ Severely impaired

Cold sensitivity: ☐ Normal ☐ Impaired

Heat sensitivity: ☐ Normal ☐ Impaired

Oral speech is: ☐ Clear ☐ Distorted but understandable

☐ Few people can understand me other than family ☐ No speech at all

My speech is: ☐ High-pitched ☐ Low-pitched

Do you use a wheelchair? ☐ Yes ☐ No ☐ Manual ☐ Electric

How much time do you spend in the wheelchair each day? _____

_____

If your wheelchair is electric, where is the control panel located? _____

_____

HEALTH HISTORY (*continued*)

For each item, on a scale of one (does not limit daily function) to 10 (fully limits daily function) answer each of the following:

	1	2	3	4	5	6	7	8	9	10	N/A
Distractibility	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Intrusive imagery	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Disassociation	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Flashbacks	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hallucinations	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Feelings of isolation	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hyper vigilance	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Fear	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Startle response	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Avoidance behaviors	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Nightmares	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Feelings of being threatened	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Aggression	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

List all medications you are on now:

_____

Please fill in the bubbles as indicated below:
Are you allergic to or do you have any adverse reaction to any of the following?:

Yes	No	Allergies or Reaction to	Explain
☐	☐	**Medication**	
☐	☐	**Food, Plants or insect bites**	

Warrior Statement

BY SIGNING BELOW, I CERTIFY THAT ALL THE ANSWERS ARE FULL AND COMPLETE.

WARRIOR SIGNATURE: _____ DATE: _____

Service Dog Tasks

Service dog tasks you require to mitigate your disability: (Please check all that apply)

- ☐ Anxiety/Depression
- ☐ Space management
- ☐ Awake from nightmares
- ☐ Open/Close doors
- ☐ Agoraphobia
- ☐ Medication reminder
- ☐ Mood swings
- ☐ Panic attacks
- ☐ Provide bracing to stand/walk/sit/balance
- ☐ Other :_____

Do you use any equipment as a result of your disability? (Please check all that apply)

☐ Crutches ☐ Cane ☐ Walker ☐ Brace ☐ Prosthetics ☐ Wheelchair

Release of Liability

I save and hold harmless said training and related parties of Heartbeat Serving Wounded Warriors, K9 Warriors, Cascade Service Dogs from any claim or lawsuit by me, my family, estate, heirs, or assigns, arising out of my enrollment and participation of this course including claims arising during or after I receive my training.

I have read and understood this agreement, and agree to be bound by it.

Signature of Participant _____ Date _____/_____/_____

Emergency Authorization

During field oriented programs, emergencies may develop at any time, and these emergencies may necessitate medical care, hospitalization, blood transfusions or surgery. If possible, a Heartbeat Serving Wounded Warriors® representative or Cascade Service Dogs will contact parents, guardians or personal physicians prior to such treatment. However, such contact may not be possible, depending on the nature of the emergency. Therefore, by initialing here, I authorize K9 Healing Warriors program, through the Heartbeat Serving Wounded Warriors®, or its representatives or agents, to secure medical treatment, anesthesia and surgery if needed. I understand that payment for any medical services is solely my responsibility.

Please initial here to indicate that you have read and fully understand this paragraph: _____.

Please list the name, numbers and relationship of persons you wish to be contacted in the event of an emergency.

Name _____ Relationship _____
Address _____ City _____ State_____

Zip _____ Phone No. _____ □Cell □Home □Work □Message

Alternate Name _____ Relationship _____

Address _____ City _____ State_____

Zip _____ Phone No. _____ □Cell □Home □Work □Message

Primary care physician name and phone numbers

Name _____

Address _____ City _____ State_____

Zip _____ Phone No. _____ □□Cell □□Office

Interview / Photo Release Form

I authorize Heartbeat Serving Wounded Warriors® (herein "HB") to use and permit others to use my image, voice, likeness, picture, video (collectively, "image") in all forms and media including composite or modified representations for all purposes, including educational and commercial, throughout the world and in perpetuity. I waive the right to inspect or approve versions of my image used for distribution or publication, or the written copy that may be used in connection with my image. I understand that my name will not be used unless I so authorize below. I further understand that I will not be compensated for the permission that I am granting here.

In giving this permission, I am not limited by any other agreement that I have entered into.

I release HB (including its officials, employees, representatives, agents, licensees, successors, and assigns) from any claims that may arise regarding the use of my image, including any claims of defamation, invasion of right to privacy, infringement of moral rights, rights of publicity or personality, or copyrights.

I have read and understood this agreement and I am over the age of 18. This agreement expresses the complete understanding of the parties.

Signature of participant _____ Date _____/_____/_____

Printed name of participant _____

☐ With my initials, I authorize Heartbeat Serving Wounded Warriors® to use my name in association with my image.

**** TO THE WARRIOR: YOU ARE NOT UNDER ANY PRESSURE TO SIGN THIS IN ORDER TO TAKE THE K9 HEALING WARRIORS CLASSES BY HEARTBEAT SERVING WOUNDED WARRIORS® ****