HUMANE SOCIETY of Southern Arizona

Wellness Assistance Verification Form

Full Legal Name: _____

Address, City, State, Zip: _____

Phone Number: _____

Email Address: _____

Emergency Contact Name & Phone number: _____

Please list all members of the household:

	Full legal name	Age	Relationship
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

Please list all pets in household:

	Pet's name	Age	Species	Breed	Weight	Altered (Y/N)
1.						
2.						
3.						

Program qualifications: Acceptable proof of income documents to qualify for the reduced costs associated with HSSA's Wellness Program include at least one of these: two paycheck stubs with dates from the last month of each wage earner; government award letter showing the amount of Social Security, Supplemental Security, Pension, Retirement, Survivor's Benefit, Disability; W2 or tax documentation for the previous year; AHCCCS; Food Stamps; EBT.

Gross Income Qualification Guidelines:

#of persons in hh	Annual Income to Utilize Wellness Fees
1	$16,132
2	$26,438
3	$36,299
4	$44,809
5	$52,876
6	$61,845
7	$70,814
8	$79,783

For each additional person, add $8,969

Proof of Income (please attach to this document): _____

_____

I certify that all above information is true and accurate.

Print name: _____

Signature: _____

Date: _____