



STATE OF CONNECTICUT



DEPARTMENT OF AGRICULTURE
ANIMAL POPULATION CONTROL PROGRAM

LOW-INCOME PET STERILIZATION APPLICATION

Effective 7/1/13

The Department of Agriculture/Animal Population Control Program (APCP) is providing vaccination and sterilization benefits for your pet (s) on a limited basis. If approved, you may be eligible to receive up to two (2) spay/neuter vouchers per household. The voucher provides a one-time benefit of \$50 for a male cat, \$70 for a female cat, \$100 for a male dog and \$120 for a female dog along with two presurgical vaccinations. Vouchers are good for only 60 days. NO EXCEPTIONS!

The veterinarian may require additional services, which the pet owner will be required to pay for. Please complete the reverse side of this form to determine your DSS eligibility.

Please list your pets below:

Pet 1:

Dog Cat Male Female

Breed:

Color:

Age:

Pet 2:

Dog Cat Male Female

Breed:

Color:

Age:

Please mail this application to the address below. Incomplete applications will be returned.

Department of Agriculture
Animal Population Control Program
165 Capitol Avenue
Hartford CT 06106

Questions? Please call 860-713-2507 or send an e-mail to apcp.agr@ct.gov. Once approved, your voucher (s) will be mailed to the address on the application with specific compliance instructions.

THIS FORM MAY BE REPRODUCED

Department of Agriculture Use Only:

Approved: Yes No Signature/DAG Official: Date:

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PERMISSION TO DETERMINE ELIGIBILITY

Name _____ Phone # _____

Address _____

City _____ State _____ Zip Code _____

I give the Connecticut Department of Social Services (DSS) permission to disclose to the Connecticut Department of Agriculture (DAG), my eligibility status for the following DSS program(s).

Do you receive assistance from any of the following programs? Check any that apply.

SNAP Temporary Family Assistance (TFA)
 Medicaid HUSKY A State Supplement
 SAGA/LIA Care 4 Kids

I understand my eligibility information provided in response to this release is no longer protected by DSS privacy regulations.

Signature of Individual or Representative DSS Client ID# or S.S. # Date

Print Your Name or Representative Name

DSS Official Use Only:

I verify that the above-named individual is eligible for the following DSS Program(s):

SNAP TFA Medicaid HUSKY A State Supp SAGA/LIA C4K

Signature of DSS Official

Date