STATE OF CONNECTICUT

DEPARTMENT OF AGRICULTURE
ANIMAL POPULATION CONTROL PROGRAM

CONNECTICUT GROWN

LOW-INCOME PET STERILIZATION APPLICATION

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. You must be a Connecticut resident to be eligible. 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. If incomplete it will be returned. The approval process usually takes about two weeks.

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 HEALTH

____ SAGA ____ State Supplement

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 HEALTH ___ State Supp ___ SAGA

_____ _____
Signature of DSS Official *Date*

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