



SPAY & NEUTER ASSISTANCE PROGRAM (SNAP) APPLICATION FORM

Pet overpopulation is a huge problem. As a responsible pet owner, it is up to you to spay & neuter your animal. WE CAN HELP! The Medicine Hat SPCA in coordination with the City of Medicine Hat and Cypress County is offering a Spay & Neuter Assistance Program (SNAP). This program is for individuals facing financial difficulties.

All applications are approved based on a level of financial need; therefore, it is important to provide accurate information. Financial need is determined by providing proof of household annual income.

APPLICANT INFORMATION

(Applicants are required to show government issued ID to validate address)

Applicant (pet owner) name _____

Phone number _____ Email _____

Address _____ Cypress County or Medicine Hat

City _____ Province _____ Postal code _____

Please provide the following to verify income:

- Recent Income Tax Notice of Assessment (NOA) (required)
- Assured Income for the Severely Handicapped (AISH) documentation (if applicable)

PET INFORMATION

Pet Name	Cat/Dog	Breed/Colour	Male/Female	Age

How did you hear about this program? _____

Where did you acquire your animal? _____

Would you like to have your animal(s) microchipped for an additional \$20/each? YES NO

APPLICANT DECLARATION

I certify that the information provided in this application is accurate and complete. I understand that:

- Submission does **not** guarantee approval.
- The MHSPCA may verify any information provided.
- **All fees paid by the applicant are non-refundable.** Approved applicants must attend surgery within the specified timeframe. **There is a fee of \$75.00 for missed appointments.** The fee must be paid prior to another appointment being made.

Applicant Signature _____ Date (mm/dd/yyyy) _____

Any questions, please call
403-526-7722

Submit completed form and supporting documents **in-person** at the shelter:

Address: 55 Southwest Drive SW, Medicine Hat, Alberta, T1A 8E8

Hours: Tuesday to Saturday, 12 p.m. to 5 p.m.

SPCA Use Only (Office Staff Completion)

Status: Approved

Clinic _____

Cost _____ + M/C _____ = \$ _____

Appointment Date _____

M/C # _____

Confirmed _____

MHSPCA Initials _____ Date (mm/dd/yyyy) _____

Paid _____ Date (mm/dd/yyyy) _____

Notes:
