



STATE OF CONNECTICUT



DEPARTMENT OF AGRICULTURE
ANIMAL POPULATION CONTROL PROGRAM

LOW-INCOME PET STERILIZATION APPLICATION

Effective 7/1/11

The Department of Agriculture is providing on a limited basis, assistance to help with vaccination and sterilization costs for your pet(s). If approved, you may be eligible to receive up to two (2) spay/neuter vouchers per household. The voucher provides up to \$50 for a male cat, \$70 for a female cat, \$100 for a male dog and \$120 for a female dog. The voucher also provides for one (1) rabies and one (1) distemper combination vaccination available ONLY when the pet is sterilized. You may be required to pay for additional services as specified by the veterinarian. If you are not prepared to pay for added services, please do not submit this application.

You must complete the reverse side of this form to determine if you are eligible for this program.

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:

Animal Population Control Program
Room G-8A
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 listed 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