



STATE OF CONNECTICUT

DEPARTMENT OF AGRICULTURE
ANIMAL POPULATION CONTROL PROGRAM



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*