

## SAFE at Home Program Application

Use this form to request short term assistance through the SAFE at Home community assistance program. Please note that submitting an application does not mean it will be approved.

**SAFE is located in the state of Washington, USA, and is only able to help horses and horse owners in WA state. Please do not submit this application if you do not reside in Washington state. Visit <https://homesforhorses.org/member-directory/> for a list of horse rescues in your state.**

### What type of assistance are you seeking?

- ☐ Hay Bank Voucher
- ☐ Veterinary Care Voucher
- ☐ Gelding Voucher
- ☐ Euthanasia Assistance
- ☐ Other

Your Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: Washington ZIP Code: \_\_\_\_\_

Do you rent or own, and for how long: \_\_\_\_\_

How many horses do you currently own: \_\_\_\_\_

### Horse 1

Horse 1 Name: \_\_\_\_\_

Horse 1 Age (or Date/Year of Birth) : \_\_\_\_\_

Horse 1 Sex: \_\_\_\_\_

Horse 1 Breed: \_\_\_\_\_

Horse 1 Physical Condition: \_\_\_\_\_

Date of Horse 1's Last Dental Float : \_\_\_\_\_

Date of Horse 1's Last Farrier Appt: \_\_\_\_\_

### Horse 2

Horse 2 Name: \_\_\_\_\_

Horse 2 Age (or Date/Year of Birth) : \_\_\_\_\_

Horse 2 Sex: \_\_\_\_\_

Horse 2 Breed: \_\_\_\_\_

Horse 2 Physical Condition: \_\_\_\_\_

Date of Horse 2's Last Dental Float: \_\_\_\_\_

Date of Horse 2's Last Farrier Appt: \_\_\_\_\_

**Horse 3**

Horse 3 Name: \_\_\_\_\_

Horse 3 Age (or Date/Year of Birth): \_\_\_\_\_

Horse 3 Sex: \_\_\_\_\_

Horse 3 Breed: \_\_\_\_\_

Horse 3 Physical Condition: \_\_\_\_\_

Date of Horse 3's Last Dental Float: \_\_\_\_\_

Date of Horse 3's Last Farrier Appt: \_\_\_\_\_

**Fill out this section to request a Hay Bank Voucher**

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*HOW THE HAY BANK PROGRAM WORKS: Hay and/or grain will be purchased by SAFE for you from a feed store of your choice that accepts credit card payments over the phone. You will be notified by SAFE when your order is ready for pick up and asked to do so within 48 hours of order placement (or sooner, depending on the pick-up policy of the feed store you've chosen.) You will be asked to show identification before your order will be released at the feed store, and you must transport the order yourself to your horse's location.*

Have you received hay bank assistance from SAFE or any other rescue before? ☐ Yes ☐ No

How many pounds of hay do you feed per day: \_\_\_\_\_

Approximately how much hay do you have on hand right now: \_\_\_\_\_

How much hay can you store on your property: \_\_\_\_\_

Type of Hay or Feed you are requesting: \_\_\_\_\_

Feed Store Name: \_\_\_\_\_

Feed Store Phone Number: \_\_\_\_\_

*Before submitting your application, please contact the store to verify that your feed store will accept credit card payment over the phone, that it has the type of hay and grain you're requesting in stock currently, that it has a pick up policy that you can work with.*

Do you understand that you must pick up your hay within the time frame set by the store and transport it to your horse's location yourself? ☐ Yes ☐ No**Fill out this section to request a Vet Care Voucher**

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Veterinarian Name: \_\_\_\_\_

Name and City of Vet Practice: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Type of vet care needed (please be as specific as possible): \_\_\_\_\_

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\_\_\_\_\_

\_\_\_\_\_

*Vet vouchers may be used for exams, blood work, and emergency dental care.*

**Fill out this section to request a Gelding Voucher**

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*PLEASE NOTE: If your vet comes out and is not able to perform the procedure because you are not there, or because of the behavior of your horse, SAFE will not pay for the failed appointment. You will be responsible for 100% of any charges that stem from a missed or failed appointment.*

Name of Vet Practice you would prefer to use: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Has your colt or stallion received a tetanus shot and/or booster?

☐ Tetanus Only    ☐ Tetanus and Booster    ☐ Neither

Is your colt or stallion halter trained?    ☐ Yes    ☐ No

Is there a dry area with soft ground at your horse's location where the vet can perform the surgery?

☐ Yes    ☐ No

Are you able to perform the required post-surgery forced exercise?    ☐ Yes    ☐ No

(10-15 minutes of trotting, twice a day, for two weeks)

**Fill out this section to request help through our Euthanasia/Serenity Fund**

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Name of Vet Practice you would prefer to use: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Briefly describe your horse's situation or condition: \_\_\_\_\_

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**Statement of Need (Must be filled out by all applicants)**

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*The SAFE at Home program is designed to assist horse owners who are struggling to afford care or feed for their horses. We have limited funds available and it's important that they are used to help people who really need our help.*

*Before we grant temporary assistance, we need your assurance that you have a plan in place to improve your situation for the welfare of your horse(s). If you're able to share your thoughts on this plan as part of this application, that would be very helpful to us as we consider your request for assistance. We may ask you to provide more detailed information about your action plan as part of the decision-making process.*

Your Annual Household Income: \_\_\_\_\_

Reason(s) for seeking financial assistance: \_\_\_\_\_

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Please describe your plan to either: (1) become financially capable of supporting your horses;  
OR (2) to responsibly rehome your horses within three months.

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### Next Steps

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*Your application will be reviewed by the Outreach team and a representative from SAFE will be in contact with you within 1-3 business days. If you need immediate or emergency assistance, please email **outreach@safehorses.org***

Best time of day to reach you by phone: \_\_\_\_\_

Anything else you'd like to add? \_\_\_\_\_

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How did you hear about the SAFE at Home program? \_\_\_\_\_

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I do hereby attest that the information I have provided is true, accurate, and complete, to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact may disqualify me from receiving assistance from SAFE now and in the future.

If you agree with this statement, please sign:

Signature: \_\_\_\_\_ Date \_\_\_\_\_

Printed name: \_\_\_\_\_

Mail your application to:

SAFE at Home  
PO Box 2769  
Redmond WA 98073