Alabama Veterinary Medical Foundation

P.O. Box 640279
Pike Road, AL 36064
334-513-2993 (p*hone)*

Application for Reimbursement from the Urgent Care Fund

The Alabama Veterinary Medical Foundation has revised a previously successful program to support participating veterinary hospitals. This program provides urgent care funds to help meet the need for pets who require urgent veterinary care to save their life, but who's pet parents simply cannot provide those financial resources in their time of need. Please remember that no payments will be made for routine care such as vaccinations, deworming, elective surgeries, etc.

Please complete the fillable PDF request form. Incomplete or illegible forms will delay the processing of your request. Submit the Grant Request Form along with a copy of the itemized treatment invoice and required verification documents to the Alabama Veterinary Medical Foundation to: tbeasley@beasleymgmt.net or fax to 334-513-2993. Forms must be submitted electronically with the attached required documents for processing.

Awards for reimbursable expenses incurred in animal treatment care may be granted up to a maximum of $500 per case. All requests must be submitted by a member in good current standing of the Alabama Veterinary Medical Association (ALVMA) and an active participant in the ALVMF Spay/Neuter Program. Payments will be made directly to the ALVMA member’s clinic. There is a limit per veterinary hospital of $1,000 annually.

All awards are made based on merit and availability of funds.

Alabama Veterinary Medical Foundation

URGENT CARE GRANT REQUEST FORM

Veterinary Facility: ____

Doctor name: ____

Address: ____
Street City State Zip

Contact info: ____
Phone E-mail

Please check all that apply:
AVMA Member Current ALVMA Member
Local VMA Member (please specify:_______)
ALVMF Spay/Neuter Program Active Participant

Client name: ____

Address: ____
Street City State Zip

Contact info: ____
Phone E-mail

Pet's Name: ____

Description: ____
Species Breed Sex Age Color

Description of illness/injury:

Financial need determined by: ____
(Attach copy of Medicaid card and photo ID or copy of Care Credit declined application with key number.)

Total amount billed for treatment: $___________ **Amount paid by client:** $___________
(Attach copy of itemized invoice.)

The pet has a good or excellent prognosis for survival after treatment: Yes No

I certify the statements herein are true, complete and accurate to the best of my knowledge. I am aware that any false, fictitious or fraudulent statements or claims may subject me to criminal, civil or administrative penalties. I agree to accept responsibility for providing any personal reports if a grant is awarded as a result of this application.

____/______________________
Signature of veterinarian Date
(If other extenuating circumstances apply, attach additional sheet with information for consideration.)

For ALVMF Use only:

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Date received / Board action / Amount awarded