2018 WINSLOW THERAPEUTIC CENTER
PARTICIPANT'S APPLICATION AND HEALTH HISTORY UPDATE

This information must be updated annually.
For the purposes of grants and other funding we request that you fill out ALL information in this packet.

WELCOME TO THE NEW YEAR HERE AT WINSLOW THERAPEUTIC RIDING CENTER!!!!! 2018

*If you have **not** had any changes to you current health or medications, please fill out this condensed update.*
*If you **do** have any changes, you are required to fill out a new Participant Application AND Physician Release.*
***Participants with Down syndrome are required to have an annual medical clearance from a licensed physician that includes a neurological exam that specifically denies any symptoms consistent with atlantoaxial instability (AAI).**

PARTICIPANT NAME____ DATE________________

AGE_____ HEIGHT________ WEIGHT______ Best number to contact for schedule changes, etc:_______________________

Can we text you with changes, etc.? YES_____ NO_____ If yes, cell phone for text________________________________

Email address:____(I would like to be added to your e-mail list)

Cancellation policy: Winslow requires 24 hour cancellations for all lessons. Failure to do so will result in a $25.00 charge. ____Initial

Bad Weather: Classes will only be cancelled in the event of dangerous or threating weather. To determine cancellations you can call Winslow directly at 845-986-6686. If we have not been able to reach you in the event we need to close there will be a message on our main voicemail. ____ Initial

Late Participant Policy: It is important for the participant to arrive 5 minutes prior to the scheduled riding time. If a client is more than 15 minutes late to a lesson, Winslow cannot guarantee he/she will be able to ride. Horses will be untacked and volunteers will be released 15 minutes after the scheduled start time of the class as well as the participant will be charged full lesson fee. If a Winslow instructor is running late your full lesson time will still be granted. ____Initial

LIABILITY RELEASE_________________________________(PARTICIPANTS NAME) would like to participate in the Winslow Therapeutic Riding Program. I acknowledge the risks and potential for risks of horseback riding. However, I feel the possible benefits to myself/my child/my ward are greater than the risk assumed. I hereby intend to be legally bound, for myself, my heirs and assigns, executors and administrators, waive and release all claims for damages against Winslow Therapeutic Riding Unlimited, Inc. its Board of Directors, Instructors, Therapists, Aids, Volunteers, and Employees for any and all injuries and losses, I/my child/my ward may sustain while participating in the Winslow Program.

Date___________ PRINT NAME____

CLIENT, PARENT, GUARDIAN, CAREGIVER SIGNATURE____

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CONFIDENTIALITY AGREEMENT:

I agree to respect and observe privacy and confidentiality of the participants, volunteers and personnel of Winslow Therapeutic Riding Center and not to discuss or disclose any sensitive information about any person or their family.

Participants Name: ____ Date: ______________

CLIENT, PARENT, GUARDIAN, CAREGIVER SIGNATURE____

PHOTO RELEASE (optional): I HEREBY CONSENT TO AND AUTHORIZE THE USE AND REPRODUCTION BY Winslow of any and all photographs and any other materiel, educational activities, exhibitions or for any other use the benefit of the program.

☐ DO CONSENT ☐ DO NOT CONSENT

Date____________CLIENT, PARENT, GUARDIAN, CAREGIVER SIGNATURE____

RESPONSIBLE PARTY FOR BILLING:

Name ____ (Participants name) ________________________________

Mailing address _______________________________________ City __________________ State _____ Zip ________________

Phone ______________________________ Cell phone _____________________________ Office phone ___________________

Signature _______________________________________ Relationship to rider ____

I hereby confirm that there are *no* changes to my health history and/or medications since 2016.

Client/Guardian Signature:____ Date:___________________________

Print name:____

*** There is a rider weight limit of 225 lbs.**

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ORANGE COUNTY COMMUNITY DEVELOPMENT PROGRAM
PROGRAM PARTICIPATION INCOME SURVEY FORM – LIMITED CLIENTELE

Facility Name: ____________ Facility Address: ____________

Program Name: ____________ Number of Family Members Enrolled in Program: ______ Enrollment Date: ______

Date: ______ Participant's Place of Resident-Town/Village of: ____________ Participant's Address (Residence) ____________

SECTION I: INCOME

For statistical purposes only, in the chart below, please circle the number of persons in the family (on the top row); then circle whether the total family income is above or below the listed amount under that family size, please include any related, dependent person over 65 or working dependent children over 18). *Total yearly income includes all sources of income for all family members residing in the household.

EXAMPLE: If your family consist of 2 people and your total yearly income is $37,500; you would circle "2 PERSON AND Row {1} - "Equal to or Less Than $37,850".

Number In Household)	1 PERSON	2 PERSON	3 PERSON	4 PERSON	5 PERSON	6 PERSON	7 PERSON	8 PERSON
{1} Equal to or Less Than	$33,150	$37,850	$42,600	$47,300	$51,100	$54,900	$58,700	$62,450
{2} Equal to or Less Than	$50,350	$57,550	$64,750	$71,900	$77,700	$83,450	$89,200	$94,950
{3} Greater Than	$50,350	$57,550	$64,750	$71,900	$77,700	$83,450	$89,200	$94,950

SECTION II: MISCELLANEOUS STATISTICAL INFORMATION

Do you or anyone in the family: *Receive Child Support/Alimony? Yes ☐ No ☐ *Receive rental income from this property or other properties owned? Yes ☐ No ☐

Number of people in family over 62 years of age? ______ Are any family members physically disabled? Yes ☐ No ☐ If Yes, indicate how many ______

Tenancy: Indicate if you are the Owner of this property or a Renter, Owner ☐ Renter ☐

How many families currently reside at this address?______ (if more than one family, each family must complete a separate questionnaire).

RACIAL AND ETHNIC GROUPS - See Page 2 of this form for Racial and Ethnic Group Definitions.

CDBG Program requires both racial and ethnic information for all beneficiaries. From the list below, check (☐) the racial and ethnic group that most closely reflects your ethnic origins.

Please check the ethnic group to which you belong: Hispanic or Latino______ Not Hispanic or Not Latino______

Please check the racial group to which you belong:

- ☐ White
- ☐ Asian
- ☐ Asian & White
- ☐ Other Multi Racial
- ☐ Black/African American
- ☐ Black/African American & White
- ☐ Native Hawaiian/Other Pacific Islander
- ☐ American Indian/Alaska Native
- ☐ American Indian/Alaska Native & White
- ☐ American Indian/Alaska Native & Black/African American

Print Name and Title of Interviewer Completing This Form: ____________ Interviewer's Signature: ____________

Revised Section 8 Income Limits - Effective April, 2018, Notice HUD PDR