Winslow THERAPEUTIC CENTER
"Healing with Horses"
SINCE 1974

PREMIER ACCREDITED CENTER
PATH INTERNATIONAL
Professional Association of Therapeutic Horsemanship International

PARTICIPANT APPLICATION

Today's Date: _____

Participants Name: _____

Best phone number to contact for schedule changes, etc.: _____

Can we text you with schedule changes, etc.? yes ____no _____ If yes, cell phone for text _____

Email Address: _____

RESPONSIBLE PARTY FOR BILLING:

Name _____ (participants name) _____

Mailing address _____ City _____ State ___ Zip _____

Phone _____ Cell phone _____ Office phone _____

Signature _____ Relationship to rider _____

Dear Participants of Winslow Therapeutic Riding Center:

Thank you for your interest in becoming a participant with us! Winslow's mission is "Healing with Horses". Winslow is a not-for-profit 501(c)(3) organization and a PATH Intl. Premier Accredited Center. All of our instructors are certified by PATH, Intl. (Professional Association of Therapeutic Horsemanship, International). Winslow has been providing therapeutic riding and equine assisted activities to the greater tri-state area since 1974.

Here at Winslow we strive to provide the safest conditions as well as a state of the art facility. In order to maintain our excellence, we ask that all participants and or their families adhere to our policies. Please review the following policies for Winslow Therapeutic Riding Center below. Failure to commit to these policies will result in loss of riding and or barn time at the participant's cost. Please initial next to each policy as well as sign and date the bottom of this form.

Thank you and welcome to Winslow!

PARTICIPANT POLICIES:

An annual update of the Participants Application and Medical Forms is required. This includes but is not limited to the Participant's application, full health history, all medications if applicable, all liability and photo releases, authorization for emergency medical treatment as well as Section 1 on the participation income form**. Should a participant need to take a break for medical reasons a physician's release will be required prior to resuming lessons. **_____Initial**

Winslow Therapeutic Riding Center is required by the Orange County Community Development Office (OCCD) to track the income range of all participants in order to continue receiving funding which subsidizes **ALL lesson costs.

Using the required Program Participation Income Survey form located on the back of this packet, in Section 1 please circle the applicable income limit listed under that household size.
Section II of the form is voluntary.

Winslow is committed to keeping the confidentiality of all client information and submits it anonymously. As you UPDATE the participant's application and fill out the OCCD form, please be assured that all data is held in strictest confidence.

Thank you for helping Winslow qualify for funding that benefits all of our clients.

Helmets Policy: When near/on horses, participants must wear A STM-SEI-approved riding helmets. Winslow does provide these helmets to those that need them. Please note bike helmets and or ski helmets are not acceptable. **____Initial**

Clothing Requirements: Long pants and closed-toe shoes (with heels if possible) is required. **____Initial**

Cancellation policy: Winslow requires 24 hour cancellations for all lessons. Failure to do so will result in a $25.00 charge for each no show/no call. **____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 that we need to close there will be a message on our main voicemail. **____Initial**

Late Rider 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**

Siblings: If siblings are in attendance with parents and or caregivers to the client participating in class, parents are responsible for the direct supervision of these children at all times. Noises and lots of activity can distract horses and other students. **____Initial**

Weight Limit: Rider weight limit is 225 lbs. **____Initial**

Safety: Winslow reserves the right at any time to refuse any participant we cannot safely accommodate. **____Initial**

Winslow Therapeutic Riding Center looks forward to working with you. If you have any questions about the above policies, please ask.

Signing below is acknowledging that you have read and understand all of our policies and procedures here at Winslow Therapeutic Riding Center.

Participants Name: _____

Signature: _____ Date: _____
Participant, Parent or Legal guardian

Thank You for your participation in our programming.

WINSLOW THERAPEUTIC RIDING CENTER
PARTICIPANT'S APPLICATION AND HEALTH HISTORY

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.

PARTICIPANT NAME_____ DATE_____

DOB_____ AGE_____ HEIGHT_____ WEIGHT_____ GENDER_____ETHNICITY_____

ADDRESS_____

EMAIL_____ HOME PHONE_____ CELL_____

EMERGENCEY CONTACT NAME_____PHONE NUMBER_____

EMPLOYER/SCHOOL_____ PHONE NUMBER_____

PARENT/LEGAL GUARDIAN_____ PHONE NUMBER_____

ADDRESS (if different from above) _____

HOW DID YOU HEAR ABOUT WINSLOW _____

HEALTH HISTORY

DISABILITY: PRIMARY_____ SECONDARY_____

***Riders 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).**

Please indicate current or past problems in the following areas:

	Y	N	Comments
VISION			
SENSATION			
COMMUNICATION			
HEART			
BREATHING			
DIGESTION			
ELIMINATION			
CIRCULATION			
EMOTIONAL			
BEHAVIORAL			
PAIN			
BONE/JOINT			
MUSCULAR			
THINKING/COGNITIVE			
ALLERGIES			
SEIZURES			
OTHER, please describe			

PLEASE LIST ALL MEDICATIONS TAKEN AND FOR WHAT PURPOSE

MEDICATION	TAKEN FOR

WINSLOW THERAPEUTIC RIDING CENTER
PARTICIPANT'S APPLICATION AND HEALTH HISTORY

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.

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

Functional Status	Independent	Some Assistance	Dependent
Sitting			
Standing			
Walking			
Wheelchair			
Dressing			
Toileting			
Feeding			

Language: Verbal_____ Sign_____ Gestural_____ Augmenative_____

Grade Level_____ Math_____ Reading_____

Explanation of Conditions/Diseases Checked_____

_____

Social Development (i.e., work/school, leisure interest, etc.) _____

_____

What form of behavior modifications do you use, if any? _____

_____

LIABILITY RELEASE_____(PARTICIPANTS NAME) would like to participate in the Winslow Therapeutic Riding Program. I acknowledge the risks and potential for risks of Equine activities. 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_____

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_____

WINSLOW THERAPEUTIC RIDING CENTER
PARTICIPANT'S APPLICATION AND HEALTH HISTORY

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.

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_____

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services or while being on the property of the agency, I authorize Winslow Therapeutic Riding Unlimited, Inc. to:

1. Secure and retain medical treatment and transportation if needed
2. Release client records upon request to the authorized individual or agency involved in the medical emergency treatment.

Client/Participants name_____ Phone: _____

Address_____

In the event I cannot be reached:

1. Contact_____ Phone: _____

2. Contact_____ Phone: _____

Physicians name_____ Phone_____

Preferred medical facility_____

Health Insurance Company_____ Policy number_____

CONSENT PLAN

☐ **I CONSENT** ☐ **I DO NOT CONSENT**

This authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure deemed "life-saving" by the physician. This provision will only be invoked if the person below is unable to be reached.

Date_____ Consent signature_____

Print name_____ Phone: _____

Address_____

This page intentionally left blank.

WINSLOW THERAPEUTIC RIDING CENTER
PARTICIPANT'S APPLICATION AND HEALTH HISTORY

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.

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 (1) 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