Participant's Application and Health History Update

To be completed at the start of each new year.
Please complete ALL information in this packet.

***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's Name: _____ DOB: _____ / _____ / _____ Age: _____
(mm/dd/yyyy)

Preferred Name: _____

Height: _____ (inches, feet) Weight: _____ lbs. Winslow has a weight limit of 225 lbs. for all **mounted** activities.

Preferred method(s) of contact: ☐ Call _____ ☐ Text _____

☐ Email _____

Legal Guardian Name: _____ Relation to Participant: _____

Home Phone: _____ Cell: _____

Address (if different from above): _____

Legal Guardian Name: _____ Relation to Participant: _____

Home Phone: _____ Cell: _____

Address (if different from above): _____

Responsible for Billing:

First and Last Name: _____ Signature: _____

Home Phone: _____ Cell: _____ Email: _____

Mailing address: _____

City: _____ State: _____ Zip: _____

Photo Release:

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.

☐ Consent ☐ Do Not Consent

Participant's Name: _____

Date: _____ / _____ / _____ Client/Parent/Legal Guardian Signature: _____
(mm/dd/yyyy)

Cancellation policy: Lesson cancellations made within 24 hours of the lesson time will incur at $25.00 charge. ____Initial

Bad Weather:
Classes will be cancelled in the event of dangerous/threatening weather. To determine cancellations, call Winslow directly at 845-986-6686. ____ 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

Weight Limit:
I understand that there is a weight limit of 225 lbs. for all mounted activities and acknowledge if the participant surpasses this weight, they will be able to participate in unmounted activities as they work towards meeting the weight limit. ____Initial

Photo and Video Recording Policy:
Winslow's confidentiality policy and photo release policy extend to participants, volunteers, animals, and staff. Prior to taking a photo or video recording your participant, you must ask the instructor to ensure that all individuals present have a photo release. There is also NO flash photography as this could startle the animals. ____Initial

Liability Release: _____ (Participant's 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: _____ / _____ / _____ Client/Parent/Legal Guardian Signature: _____
(mm/dd/yyyy)

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.

Participant's Name: _____

Date: _____ / _____ / _____ Client/Parent/Legal Guardian Signature: _____
(mm/dd/yyyy)

If participant has had changes in health history and/or medications since last year, please fill out page 4 of this document. If there are no changes to report, please sign below.

I hereby confirm that there are *no* changes to the participant's health history and/or medications since last year.

Date: _____ / _____ / _____ Client/Parent/Legal Guardian Signature: _____
(mm/dd/yyyy)

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