HOPE – HOrses helping PEople, Inc.

Eligibility Requirements & Admittance Process

Eligibility: Any person diagnosed with an emotional, physical, cognitive disability from age 2 and up is eligible to apply for enrollment into one of HOPE's programs. There are additional requirements that students must first meet before we can enroll them in our program.

1. The first step is to contact the Therapy Director at HOPE to discuss space availability. We do maintain a waiting list and move people off the list readily. Once an open spot is determined, the rider, rider's parent(s), or legal guardian must fill out copies of all the HOPE's enrollment forms. No rider may begin until all forms are received. The enrollment forms can be found on our website or may be obtained through the mail.

2. The rider and his/her parent(s) or caregivers must attend a preliminary evaluation and intake meeting with HOPE's Therapy Director. This intake and evaluation process is in place to help establish the best treatment plan possible for each individual rider. It is also the time that precautions and contraindications to riding for particular disabilities are reviewed and discussed on an individual basis.

3. For health of our horses and the safety of our riders and side walkers, we generally do **not accommodate riders in excess of 180 lbs**. Alternative means of interaction with horses will be recommended for individuals who would still like to participate in an equine-facilitated activity. If you have any questions about the suitability of any of our Equine Assisted Activities for you, please do not hesitate to contact HOPE's Therapy Director.

4. Students with specific treatment plans that include specialized emergency procedures, medical prescriptions, or actions to be taken around behavioral issues must have a parent or caregiver accompany them to each session.

5. HOPE currently accepts riders starting at age 2. Riders younger than 2 years may be accepted depending upon the findings of the initial intake with HOPE's Therapy Directyor and at HOPE's discretion. Generally speaking, children with disabilities between ages of 2-5 and adults with acute or sub-acute disability related issues are typically enrolled in HOPE's hippotherapy program. Older riders who are able are typically enrolled in Therapeutic Riding or Grooming. Although HOPE utilizes many different staff, volunteers and horses, some riders are difficult to provide for because of a physical, mental or behavioral challenge that scares or threatens those around them, most especially the horses. HOPE staff will attempt to create the best rider, horse, staff and volunteer combination possible. HOPE reserves the right to deny or remove a rider from a therapy session if their actions jeopardize the safety of the horses, staff, or him/herself.

HOPE – HOrses helping PEople, Inc.

Client Information

Client Name: ____DOB: ____________Age:____

Male Female Height:____________ Weight:____________

Disability(s):____

School/Institution attending:____

Address: ______________________________________City ________________ Zip____________

Email:_______________________________ Phone: _________________Mobile:_______________

Parent/Guardian Information

Parents/Guardian____

Address: ______________________________________City ________________ Zip____________

Email:_________________________ Phone: __________________Mobile:____________________

PHYSICAL FUNCTION(i.e. mobility skills such as transfers, walking, wheelchair use)

____
____
____

PSYCHO/SOCIAL FUNCTION(i.e. work/school including grade completed, leisure interests, relationships, family structure, support systems, companion animals, fears/concerns, etc.)

____
____
____

GOALS(i.e. why are you applying for participation? What would you like to accomplish?

____
____
____

HOPE – HOrses helping PEople, Inc.

EMERGENCY MEDICAL TREATMENT FORM

Name: ____ DOB: _________________________

Address: ____

City: ____ Zip: __________________

Physician's Name: ________________________ Preferred Medical Facility ____________________________

Allergies: ____

Current Medications: _________________________________ Date of Last Tetanus Shot: _________________

In the event of an emergency, contact:

Name: ___________________________ Relation: _____________________ Phone: _______________

Name: ___________________________ Relation: _____________________ Phone: _______________

Consent Plan:

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 HOPE – HOrses helping PEople, 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.

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(s) above is unable to be reached.

Consent for treatment, please check box:

I DO CONSENT **I DO NOTCONSENT**

Date: ________________

Rider Signature:____

Parent/Guardian Signature (if under 18):____

Photo Release

I do I Do Not

Consent to and authorize the use and reproduction by HOPE – HOrses helping PEople, Inc. of any and all photographs and any other audio/visual materials taken of me for promotional material, educational activities, exhibitions or for any other use for the benefit of the center.

Date:________________

Rider Signature:____

Parent/Guardian Signature (if under 18):____

9722 SW 153rd Avenue ·PO Box 1177 · Archer, Florida32618 · 352.495.0533
www.horseshelpingpeople.org

HOPE – HOrses helping PEople, Inc.

Referring Physician Information

Physician's Last Name: ______________________ First: _____________________Middle Initial: _______

Business Phone Number: ____________________ Practice Specialty____

Physician's Address:____

Carrier Name: ____ Phone Number: _____________________

Claims Address: ____

City:_____________________________ State:______________ Zip Code:_________________

In the event you were referred by another health professional other than above physician:

Referral Source Last Name: __________________ First: _____________________Middle Initial: _______

Business Phone Number: ____________________ Practice Specialty: ____

Referral Source Address: ____

City:_____________________________ State:______________ Zip Code:_________________

Guarantor Information

Guarantor's Last Name: ________________________First: _____________________Middle:______________________

Relationship to Patient: ________________________ Sex: Male Female

Address:____ Phone Number: _____________________

City:_______________________________ State:_______________ Zip Code:____________

Guarantor's Employer Name: _____________________________________ Occupation: ______________________

Address:____ Phone Number: __________________

City:_______________________________ State:_______________ Zip Code:________________________________

Length of Employment: _______________________

Next of Kin Information

Name: ____ Relationship to Patient: ________________________

Phone Number: _________________________(h) ___________________________(c) ________________________(w)

HOPE – HOrses helping PEople, Inc.

Primary Insurance Information

Carrier Name: ____ Phone Number: ______________________________

Claims Address: ____

City:____________________________ State:______________ Zip Code:____________________________

Subscriber's Last Name: ___________________________First: _________________ Middle Initial: _______

Relationship to Patient: ____________________________ Social Security Number: ____________________

Date of Birth: ____________________ Certificate And/Or Policy Number:______________________________________

Effective Date: ___________________ If Group Insurance, Give Employer Name: _______________________________

Group Number:__________________________________ Plan Number: ______________________________________

Secondary Insurance Information

Carrier Name: ____ Phone Number: ______________________________

Claims Address: ____

City:____________________________ State:______________ Zip Code:_____________________________

Subscriber's Last Name: ___________________________First: _________________ Middle Initial: ________

Relationship to Patient: ____________________________ Social Security Number: _____________________

Date of Birth: ____________________ Certificate And/Or Policy Number:______________________________________

Effective Date: ___________________ If Group Insurance, Give Employer Name: _______________________________

Group Number:__________________________________ Plan Number: ______________________________________

I certify that the above information to be correct and true. I authorize the release of any information to process the claim. I understand that I am ultimately responsible for all treatment cost REGARDLESS OF INSURANCE COVERAGE and that a minimum of 20% of my outstanding balance is due 15 days from the statement date. I authorize the application of a reasonable finance charge to my account, should it become seriously overdue.

Signature____ Date: ______________________________

HOPE – HOrses helping PEople, Inc.

PHYSICIAN'S STATEMENT

Dear Health Care Provider:

Your patient,____________________________________ *(participant's name)* is interested in participating in supervised equine activities.

In order to safely provide this service, our center requests that you complete/update the attached Medical History and Physician's Statement Form.

Please note that the following conditions may suggest precautions and contraindications to equine activities. Therefore, when completing this form, please note whether these conditions are present, and to what degree. Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in equine assisted activities, please feel free to contact the center at the address/ phone below.

Orthopedic	**Medical/Psychological**	**Neurologic**
Atlantoaxial Instability - include neurologic symptoms CoxaArthrosis Cranial Deficits Heterotopic Ossification/ Myositis Ossificans Joint subluxation/dislocation Osteoporosis Pathologic Fractures Spinal Joint Fusion/Fixation Spinal Joint Instability/ Abnormalities	Allergies Animal Abuse Cardiac Condition Physical/Sexual/Emotional Abuse Blood Pressure Control Dangerous to self or others Exacerbations of medical conditions (i.e. RA, MS) Fire Settings Hemophilia Medical Instability Migraines PVD Respiratory Compromise Recent Surgeries Substance Abuse Thought Control Disorders	Hydrocephalus/Shunt Seizure Spina Bifida/Chiari II malformation/Tethered Cord/ Hydromyelia **Other** Age - under 4 years Indwelling Catheters/ Medical Equipment Medications - i.e. photosensitivity Poor Endurance Skin Breakdown

Physician's Notes

____

____

____

Date:__________________

Physician's Signature:____

HOPE – HOrses helping PEople, Inc.

PHYSICIAN'S STATEMENT

Participant:____

DOB:__________________Height:__________________Weight:______________

Address:____

Phone:_______________________(h)_______________________(c)___________________(w)

Diagnosis:____

Date of Onset:___________________

Past/Prospective Surgeries: ____

____

Medications:____

Seizure Type:____ Controlled □ Y □ N

Date of Last Seizure:___________

Shunt Present □ Y □ N Date of Last Revision: ___________________

Special Precautions/Needs: ____

Independent Ambulation: □ Y □ N Assisted Ambulation: □ Y □ N Wheelchair: □ Y □ N

Braces/AssistiveDevices:____

For those with Down Syndrome:

AtlantoDens Interval X-rays Date:__________________ Result: + --

Neurological Symptoms of AtlantoAxial Instability:____________________________________

HOPE – HOrses helping PEople, Inc.

PHYSICIAN'S STATEMENT

Please indicate current or past special needs in the following systems/areas, including surgeries:

	Y	N	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine assisted activities. I understand that the NARHA center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the NARHA center for ongoing evaluation to determine eligibility for participation.

Name/Title: ____MD DO NP PA Other ___________________
Physician's Signature: ____ Date: ____________
Address: ____
City:__________________________State__________________Zip_____________________
Phone:______________________________
License/UPIN Number:____

HOPE – HOrses helping PEople, Inc.

Payment Agreement

I understand the therapist will help bill insurance and deductibles/co-payment is due by cash or check at the time of treatment, unless prior arrangements have been made.

Paperwork for submittal of insurance claims independently may be requested. I understand and accept ultimate responsibility for payment of my account.

I have read and understand this policy
Date: ________________
Rider Signature: ____
Parent/Guardian Signature (if under 18): ____

Cancellation Policy

Cancellations/Make-ups: I understand that if I must cancel a session, a 24-hour notice is required. U understand that failure to notify the therapist of a cancellation 24 hours ahead of time will result in the normal cost of therapy session being charged.

I also understand that I may reschedule any cancelled therapy sessions.

We recognize and assess individual needs. Excessive cancellations may cause a loss of reserved time.

I have read and understand this policy
Date: ________________
Rider Signature: ____
Parent/Guardian Signature (if under 18): ____

HIPAA Statement

HOPE will identify and evaluate the likelihood and consequences of threats to the security of Protected Health Information and implement reasonable and appropriate measures to safeguard the confidentiality, availability, and integrity of that information. HOPE will adopt and implement HIPAA security practices outlined in the approved HIPAA Security Procedures.

This policy applies to all members of the HOPE workforce, along with all independent contractors and volunteers who provide services that require access to health records. They will be required to adhere to the policies and procedures in the HIPAA Security Procedures, as well as any procedures established to support this policy.

HOPE will safeguard information in a manner consistent with applicable requirements of federal, state and local law and regulations, including the final rule governing the security of health information systems enacted by the Department of Health and Human Services as required by HIPAA.

HOPE – HOrses helping PEople, Inc.

EQUINE ACTIVITY LIABILITY RELEASE, WAIVER OF RIGHT TO SUE AND ASSUMPTION OF ALL RISKS READ BEFORE SIGNING

This Equine Activity Liability Release, Waiver of Right to Sue and Assumption of All Risks Agreement (the "Agreement") is hereby given by ______________________________________ on his/her own behalf HOPE – HORSES HELPING PEOPLE, INC., a Florida not for profit corporation, as the equine activity sponsor (the "Sponsor"), and to each officer, director, agent, employee, volunteer, equine professional (as defined in the Act referenced herein), instructor, therapist, aide, heir, personal representative, successor and/or assign of the Sponsor (who also shall be included within the word "Sponsor") and agrees as follows:

In consideration for the opportunities provided by the Sponsor to the undersigned, including any minor or legal ward in whose behalf the undersigned signs this Agreement (collectively, the "Participant"), for the enjoyment of equine activities and the use of the Sponsor's facility and equipment, the Participant hereby agrees as follows:

1. This Agreement is given in part under the Florida Equine Activities statutes (Chapter 773) as it may now provide or be hereafter amended (the "Act"). All terms defined by the Act shall have the same meaning herein, and the Act is hereby incorporated in this Agreement by reference. This Agreement shall be so construed as to provide to the Sponsor the fullest protection of a release, waiver of claim and recovery, right to sue and assumption of all risks that is afforded by the Act, and by other applicable statutes and general law.

2. The Participant hereby acknowledges that he/she has full and complete notice and understanding of the Act and of all the dangers and/or conditions which are an integral part of equine activities which may cause, contribute to or result in the death or personal injury of the Participant or damage to the Participant's property (the "Risks"), including, but not limited to:

- The propensity of equines to behave in ways (such as, but not limited to, buck, stumble, fall, rear, bite, kick, run, and make unpredictable movements, spook, jump obstacles, step on a person's feet, push or shove a person, saddles or bridles may loosen or break) that may result in injury, harm, or death to persons on or around the equine;
- The unpredictability of an equine's reaction to sounds, sudden movement, persons, other animals, or unfamiliar objects.
- Hazards, including, but not limited to, surface or subsurface conditions;
- A collision with another equine, another animal, a person, or an object;
- The potential of an equine activity participant to act in a negligent manner that may contribute to injury, death, or loss to the person of the participant or to other persons, including, but not limited to failing to maintain control over an equine or failing to act within the ability of the participant.
- The inability of anyone whomsoever to predict or foresee an equine's reaction to excitement, weather conditions, sound, movements, objects, vehicles, persons, animals, reptiles, birds or insects, and the effects of such reactions.
- The dangers and risks of tack or harness, loosening, slipping or breaking for whatever reason.
- The dangers and risks of becoming entangled in tack, harness, or vehicles used in an equine activity.
- The risks of falling from or otherwise becoming unstable on an equine or a vehicle used in an equine activity for any reason whatsoever or for no identifiable reason.
- Any negligent act or omission by the Sponsor which causes or results in the death or personal injury of the Participant or damage to the Participant's property.

3. The Participant hereby expressly assumes all risks and dangers of injury, loss, damage or death which are in any way resulting from the inherent risks of equine activities and/or associated with the Risks enumerated in paragraph 2 above.

4. The Participant hereby releases and waives all rights which he/she may have or hereafter have against the Sponsor for injury, loss, damage or death which is in any way resulting from the inherent dangers of equine activities and/or associated with the Risks enumerated in Paragraph 2 above, and the right to sue or to bring any action against the Sponsor in connection therewith. The Participant agrees to completely indemnify and hold the

Sponsor harmless from and against any and all claims, demands, causes of action, suits, actions, losses, liabilities, costs and/or expenses, including medical costs and attorney's fees, which are occasioned by, or otherwise attributable to, matters for which the Participant has hereby assumed the risk and is responsible in accordance with this Agreement.

5. The Participant agrees to comply with all rules and regulations posted or otherwise communicated by the Sponsor. The Participant agrees that the Sponsor has made reasonable and prudent efforts to determine the Participant's ability to engage in the Equine Activity offered by the Sponsor and the Participant has disclosed all known physical and psychological conditions
to Sponsor to assist Sponsor in evaluating the Participant for participation in the Equine Activity offered by the Sponsor.

6. The Participant agrees that mounting, riding, walking, dismounting, grooming, training, handling, feeding, and otherwise being in the physical proximity of horses is a dangerous activity which produces a foreseeable risk of mortal or serious personal injury and/or property loss to the Participant in such activity as well as to the person or property of others.

7. This Agreement shall remain valid and in full force and effect from and after the date opposite the signature of the Participant until expressly revoked by the Participant in a written notice personally delivered to the Sponsor.

8. This Agreement shall be construed under Florida law in such manner as will render it, and each provision of it, fully enforceable; provided, however, that if any provision of this Agreement shall be unenforceable, such provision (or so much thereof as is unenforceable) shall be deleted and the remainder of this Agreement shall continue in full force and effect. Venue for purposes of any litigation or arbitration concerning this Agreement shall be in Alachua County, Florida.

9. If this Agreement is executed by the undersigned for and on behalf of a minor Participant as named below, the undersigned hereby warrants and represents that he/she is in fact the legal parent or guardian of such minor, with full rights of custody and control; that this Agreement is given on behalf of and is intended to be binding upon said minor Participant, his/her heirs,
personal representatives, successors and assigns; and the undersigned further agrees that this Agreement shall also be as fully binding on the undersigned as if it were entered into solely on his/her own behalf.

10. This Agreement shall be binding upon the heirs, personal representatives, successors and assigns of the Participant and the undersigned.

WARNING

Under Florida law, an equine activity sponsor or equine professional is not liable for an injury to, or the death of, a participant in equine activities resulting from the inherent risks of equine activities.

I HAVE FULLY READ AND FULLY UNDERSTAND THE FOREGOING EQUINE LIABILITY RELEASE, WAIVER OF RIGHT TO SUE AND ASSUMPTION OF ALL RISKS. I HAVE CONSULTED AND RELIED UPON MY OWN ADVISORS ON ALL QUESTIONS IN CONNECTION THEREWITH AND FULLY UNDERSTAND ITS TERMS, UNDERSTAND THAT I HAVE GIVEN UP SUBSTANTIAL RIGHTS BY SIGNING IT, AND SIGN IT FREELY AND VOLUNTARILY WITHOUT ANY INDUCEMENT. I HAVENOT RELIED UPON THE SPONSOR FOR ANY ADVICE OR EXPLANATION IN CONNECTION THEREWITH.

Print Name:____
Date:________________________
Signature:____

FOR MINORS UNDER 18 YEARS OF AGE:
Print Name of Minor:____
Date

HOPE – HOrses helping PEople, Inc.

NARHA

Anthony and Nanette Mancuso (and Helping Hooves, LLC)
15304 SW 91st Street
Archer, FL 32618
(352)495-4399

LIABILITY RELEASE AGREEMENT NOT TO SUE AND INDEMNITY AGREEMENT

I, ________________________, desire to take horseback riding lessons, engage in therapeutic horse riding or hippotherapy activities under the auspices of a tenant on the property of Anthony and Nanette Mancuso and/or use the horses and facilities of Helping Hooves, LLC and Anthony and Nanette Mancuso's horses and farm and residence, acknowledge that horseback riding and activities incidental thereto are inherently dangerous activities, and further acknowledge that serious injury can result from engaging in horseback riding and activities incidental thereto. In connection with the use and enjoyment of the horses and facilities of Helping Hooves, LLC and Anthony and Nanette Mancuso's horses, farm and residence and/or the furnishing of horseback riding lessons to me and/or therapeutic use of horses for my benefit, I agree on behalf of myself, and my heirs and legal representatives forever to release any member of Anthony and Nanette Mancuso's family and Helping Hooves, LLC and all of their past, present and future employees, tenants on their horse farm property and their respective heirs and legal representatives from, and agree no| to sue in connection with any and all damages, claims, demands, rights, and causes of' action based upon personal injuries or property damage to me or my death, arising out of horseback riding, lessons, the use of the horses and facilities of Anthony and Nanette Mancuso and Helping Hooves, LLC including stables, grounds, or any activities incidental thereto. I further agree to indemnify Helping Hooves, LLC and Anthony and Nanette Mancuso and to save them harmless from all damages, actions, causes of actions, claims, judgments, executions, debts, cost of litigation and attorney's fees, which may in any way rise out of or result from the furnishing of horseback riding lessons to me, therapeutic use of horses for my benefit and/or the use of the horses or facilities of Helping Hooves, LLC or Anthony and Nanette Mancuso including stables and grounds, by me and/or any activities incidental thereto at any time from the date of this Release until this Release is expressly revoked by me.

I have read and understand the above Release of Liability, Agreement Not To Sue And Indemnity Agreement, and that by executing this Agreement I acknowledge that I am giving up valuable rights.

IN WITNESS WHEREOF, I have set my hand this ____ day of ___________________

________________________________ ___________________________________
(Signature of participant or guardian) (Printed name of participant)
In the presence of:_________________________________(Witness)

WARNING!!! UNDER FLORIDA LAW, an equine activity sponsor or equine professional is not liable for injury to, or the death of, a participant in the equine activities resulting from the inherent riskof equine activities.