



True Friends
 10509 108th St. NW
 Annandale, MN 55302
 952.852.0101

Therapy and Adaptive Riding Application

FOR OFFICE USE ONLY: Application Rec'd. / / Deposit Rec'd: By _____

General Information – Tell Us About Yourself

Person filling out the application: _____ Relationship to Participant: _____

Name: _____
Last Legal First Name (Nickname) Middle Initial

Address: _____
Street (include Apt. #, if applicable) City State Zip

Telephone: (____) _____ County of Birth: _____ County of Residence: _____

Email: _____ Age: _____ Date of Birth: _____ Male ___ Female ___

Current Height: _____ Current Weight: _____ Right handed: ___ Left handed: ___ Are you your own guardian?: ___ Yes ___ No

Attend school: ___ Yes ___ No If yes, where: _____

Employed: ___ Yes ___ No Where: _____

Religious preference: _____ Race: ___ White ___ African-Am ___ Native-Am ___ Asian ___ Hispanic ___ Multi-racial ___ Other
 If other, please specify: _____

Living Situation: Res. Group Home/Apt. ___ Nursing Home ___ Private Home(with parent/guardian) ___ Lives Independently ___ Foster Home ___
 Residential Group Home/Apt. Name: _____

Corporate Owner Name: _____ Facility Address: _____

Facility Contact Person: _____ Facility Telephone: (____) _____

Facility Email: _____ Facility Cell Phone: (____) _____

Facility Nurse: _____ Nurse Phone: (____) _____

Contact Information

#1 Parent/Legal Guardian name: _____ Is parent also the guardian?: ___ Yes ___ No
 Phone number (____) _____ Cell phone (____) _____ Email: _____
 Address: _____
Street City State Zip

Place of employment: _____ Work number: (____) _____
Name of company Position/title

#2 Parent/Legal Guardian name: _____ Is parent also the guardian?: ___ Yes ___ No
 Phone number: (____) _____ Cell phone: (____) _____ Email: _____
 Address: _____
Street City State Zip

Place of employment: _____ Work number: (____) _____

Social Worker/Case Manager name: _____
 County: _____ Phone number: (____) _____ Cell phone: (____) _____
 Email: _____

Emergency Contacts: Please list two additional contacts to be reached in the event that the first two contacts cannot be reached:

#1 Emergency Contact name: _____ Relationship to you: _____
 Phone #1: (____) _____ Phone #2: (____) _____ Phone #3: (____) _____

#2 Emergency Contact name: _____ Relationship to you: _____
 Phone #1: (____) _____ Phone #2: (____) _____ Phone #3: (____) _____

All correspondence regarding the registration of this applicant will be sent to the individual chosen below. Please choose one:
 ___ Participant Email ___ #1 Parent/Legal Guardian Email ___ #2 Parent/Legal Guardian Email ___ Social Worker/Case Manager Email

Healthcare Information

Primary Doctor: _____ (____) _____
 Name Address City/State/Zip Phone

Mental Health Provider: _____ (____) _____
 Name Address City/State/Zip Phone

Dental Provider: _____ (____) _____
 Name Address City/State/Zip Phone

Medical Assistance #: _____ Medicare #: _____
 Primary Health Care Insurance Provider Name: _____
 Policy #: _____ Policy holder's name: _____

Diagnosis/Disability/Condition

What is your Primary Diagnosis? _____ Secondary Diagnosis: _____

Please check any additional diagnosis/disability/condition that apply. Conditions in ***BOLD PRINT** require an additional questionnaire, which are available for download at <http://www.truefriends.org/documents-forms>. The questionnaires must be included when you submit your application.

<input type="checkbox"/> No Diagnosis/Disability/Condition	<input type="checkbox"/> Alzheimer's or Dementia (Beginning Stage)	<input type="checkbox"/> Amputee
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Asthma
<input type="checkbox"/> Attention Deficit Disorder	<input type="checkbox"/> Attention Deficit Hyperactive Disorder	
<input type="checkbox"/> Autism	<input type="checkbox"/> Bipolar Disorder	<input type="checkbox"/> Blood Disorder: _____
<input type="checkbox"/> Brain Injury	<input type="checkbox"/> *CATHETER	<input type="checkbox"/> Cerebral Palsy
<input type="checkbox"/> Developmental-Cognitive or Intellectual Disability	<input type="checkbox"/> Depression	<input type="checkbox"/> *DIABETES – Type 1
<input type="checkbox"/> *DIABETES – Type 2	<input type="checkbox"/> Down Syndrome	<input type="checkbox"/> *FEEDING TUBE
<input type="checkbox"/> *EPILEPSY/SEIZURES . If yes, please provide protocols.	<input type="checkbox"/> Heart Problems, explain: _____	
<input type="checkbox"/> Fetal Alcohol Spectrum Disorder	<input type="checkbox"/> Muscular Dystrophy (MD)	
<input type="checkbox"/> MRSA: <input type="checkbox"/> Active <input type="checkbox"/> Inactive	<input type="checkbox"/> Obsessive-Compulsive Disorder	<input type="checkbox"/> Oppositional Defiant Disorder
<input type="checkbox"/> Multiple Sclerosis (MS)	<input type="checkbox"/> Pica	<input type="checkbox"/> Post Traumatic Stress Disorder
<input type="checkbox"/> *ORTHOPEDIC APPLIANCES	<input type="checkbox"/> Parkinson's	<input type="checkbox"/> Pervasive Developmental Disorder
<input type="checkbox"/> Paraplegia	<input type="checkbox"/> Quadriplegia	<input type="checkbox"/> Reactive Attachment Disorder
<input type="checkbox"/> Prader-Willi Syndrome	<input type="checkbox"/> Rett Syndrome	
<input type="checkbox"/> Respiratory	<input type="checkbox"/> Sensory Processing Disorder, explain: _____	
<input type="checkbox"/> Spina Bifida	<input type="checkbox"/> *TRACHEOSTOMY	<input type="checkbox"/> Williams Syndrome
<input type="checkbox"/> Tourette Syndrome	<input type="checkbox"/> Wears glasses	
<input type="checkbox"/> Blind <input type="checkbox"/> Vision impaired, no correction	<input type="checkbox"/> Wears hearing aid x 1	<input type="checkbox"/> Wears hearing aid x 2
<input type="checkbox"/> Deaf <input type="checkbox"/> Hearing impaired, no correction	<input type="checkbox"/> Right ear	
<input type="checkbox"/> Left ear	<input type="checkbox"/> Needs a staff proficient in sign language	
<input type="checkbox"/> Uses Sign Language		
<input type="checkbox"/> Other disability/diagnosis/condition, please explain: _____		

Allergies

Do you have a food allergy? Yes No If yes, please explain the food allergy and specify your reaction to the food allergy: _____

Do you have a medication allergy? Yes No If yes, please explain the medication allergy and specify your reaction to the medication allergy: _____

Do you have an environmental allergy? Yes No If yes, please explain the environmental allergy and specify your reaction to the environmental allergy: _____

Medications Taken While at True Friends

Do you carry an Epi-pen?: Yes No
 Are you bringing a rescue medication? Yes No If yes, what rescue medication are you bringing? _____

Activities of Daily Living Information

Special Appliances/Ambulation – Please provide needed equipment and complete the Orthopedic Appliance Questionnaire.

Wheelchair? Yes No If yes, please explain: Manual Electric Stroller Long distances only
Assistance in walking? Yes No Support from another person Cane Walker Slow walker May fall easily
What are the scheduled times out of the wheelchair?: _____
Assistance in transferring? Yes No
What type of transfer is used? _____ Mechanical lift: Yes No
Require **range of motion** exercises? Yes No If yes, please attach a copy of exercises.
Do you wear/use? Orthotics circle: left or right Prosthesis circle: left or right Braces/night braces
Further Instructions: _____

Bathroom Use

Assistance in bathroom? Independent Some assistance Total assistance
Use of incontinent product? Yes No

Please explain in detail the type of assistance needed in each area: _____

Communication

Able to communicate wants/needs? Yes No
 Verbal-speaks clearly Verbal-difficult to understand Uses a communication device Sign Language Non-verbal/gestures
 Uses Picture Exchange Communication System (PECS) Other type of communication device: _____
Understands/responds to questions?: Yes No Needs extra time to process information?: Yes No
Has difficulty understanding the communication of others?: Yes No Has difficulty expressing thoughts?: Yes No
Able to read?: Yes No Able to write?: Yes No
Can you indicate pain?: Yes No Please explain how: _____
Further instructions: _____

Social Interactions & Behaviors

Any fears such as animals, thunderstorms, night time, heights, large crowds, water, etc.? Yes No Explain: _____
Explain method for dealing with fears: _____

Does the participant display any behavioral issues? Yes No If yes, please check all behaviors below:

- | | | |
|---|---|--|
| <input type="checkbox"/> Self-injurious behaviors | <input type="checkbox"/> Temper tantrums | <input type="checkbox"/> Removes clothing |
| <input type="checkbox"/> Uses inappropriate language | <input type="checkbox"/> Inappropriate sexual behaviors | <input type="checkbox"/> History of stealing |
| <input type="checkbox"/> Physically aggressive toward others: | | |
| <input type="checkbox"/> biting <input type="checkbox"/> slapping <input type="checkbox"/> punching <input type="checkbox"/> kicking <input type="checkbox"/> choking <input type="checkbox"/> spitting | | <input type="checkbox"/> Rectal digging |
| <input type="checkbox"/> Physically aggressive toward property | <input type="checkbox"/> Stubbornness | <input type="checkbox"/> Food related (stealing/eating inedible objects) |
| <input type="checkbox"/> Elopes/runs away unintentionally | <input type="checkbox"/> Elopes/runs away intentionally | <input type="checkbox"/> Fecal smearing |
| <input type="checkbox"/> Displays unusual behavior toward male staff | | <input type="checkbox"/> Displays unusual behavior toward female staff |
| <input type="checkbox"/> Exaggerates/fabricates information | <input type="checkbox"/> Suicidal tendencies/thoughts | |
| <input type="checkbox"/> Other, describe: _____ | | |

What will or may trigger the above behaviors? Please check all triggers below:

- | | | |
|---|--|--|
| <input type="checkbox"/> Happens "out of the blue" | <input type="checkbox"/> Not getting what he/she wants | <input type="checkbox"/> Unwanted peer interaction |
| <input type="checkbox"/> Unwanted authoritative interaction | <input type="checkbox"/> Attention-seeking | |

Environmental factors (noise, temperature, sensory over/under stimulation). Please explain: _____

When do you see most behaviors occurring? Hungry Uncomfortable Hurt Bored Dysregulated Unknown

Other: _____

How often do these behaviors occur? Seldom (1x/month) Often (1x/week) Frequently (More than 1x/week) Daily

What behavioral indicators might exist that show the person is in distress, before a behavior exists? _____

Please explain what the behavior typically looks like, what redirection is done, and what the typical response is to redirection: _____

What are effective tools for de-escalation of the behavior?: _____

Do you anticipate any concerns with this participant going out into the community? Yes No If yes, please explain: _____

Does the participant ever require physical intervention? Yes No If yes, please explain type of intervention, purpose, and frequency: _____

Is there any physical intervention that is contraindicated medically? Yes No If yes, please explain: _____

Participant Name: _____ Date of Birth: _____

Tell Us About Your History With True Friends

Have you ever attended True Friends services?: Yes No
 Respite Summer/Day Camp Winter Camp Adventure Trip Ventures Travel Team Quest True Strides
 Conference and Retreat (school or business retreat)

Check location(s) attended:
 Camp Friendship, Annandale Camp Eden Wood, Eden Prairie Camp Courage, Maple Lake Camp Courage North, Lake George

How did you hear about True Friends?:
 Social worker Teacher Friend/family ARC DSAM AUSM Conference/Event Other: _____
 Internet search. Which site: _____

2024 Program Options

Therapy and Adaptive Riding staff will conduct an initial evaluation and recommend the most appropriate program for your specific situation.

Current program options include:

Hippotherapy (\$242.00/session) Therapeutic Riding (\$125.00/session)
 Tier 2 (\$210.00/session) Myofascial Massage (15 minute session - \$50.00/session | 30 minute session - \$100.00/session)

Fee Agreements, Cancellation Policy & Payment Information

Payment Information

I will be paying for services with Waivered Service Funds? Yes No

If yes, please check the waiver that is approved to bill: CDCS Other: _____

If CDCS, who is your Financial Management Services? _____

If using MN Waivered Service Funds, a copy of your Coordinated Service & Support Plan (CSSP) is REQUIRED with your application.

Private Pay

I will be privately paying for services? Yes No

Full payment enclosed Bill me later

To pay by check include a check with participant name in memo.

Name of Payee	Address	City	State	Zip

Cancellation Policy

If for any reason your child will be unable to make their scheduled appointment time, a 24-hour notice must be given in order to avoid being charged for the full session (Please note we **CANNOT** bill the waiver for a missed appointment, so responsibility of the full payment is on the client). We understand that sudden illnesses or emergencies arise, please call us as soon as you know your child will be unable to make their session due to illness.

Missing a session without any prior notification (no show) for any reason will be billed to the client in full. We ask that no more than three (3) cancellations occur every quarter throughout the year. The quarters will be as follows: January-March / April-June / July-September / October-December. If three (3) or more cancellations or skipped sessions occur in a given quarter, we reserve the right to schedule another family into that time slot. Sessions begin promptly at the agreed time. If the child is late for the session, the session will still finish at the scheduled time. This policy is in place out of respect for our therapists and clients. By giving last minute notice or no notice, it prevents someone else from being able to schedule into that time slot.

True Friends reserves the right to cancel a session due to circumstances beyond our control including severe weather or due to a lack of staff. If this occurs, staff will notify you within a timely manner. Clients will be rescheduled for another session or could be refunded entirely.

Extended Leave Policy

In an effort to provide effective and efficient treatment to all of our clients, it is the policy of True Friends Therapy and Adaptive Riding program, that clients taking an extended leave, exceeding three consecutive weeks, notify their therapist immediately. If a client does not notify the therapist and three consecutive weeks are missed the session time will be immediately rescheduled to another client. If your session is rescheduled, please contact True Friends if you would like to initiate therapy once again. We cannot promise that the same time, day or therapist will be available.

Release & Authorization

Admission Authorization

I hereby give permission for the applicant to participate in True Friends (TF) sponsored and supervised programs. I certify that the information on the application is true, accurate and complete. True Friends emphasizes safety first; however, participation in True Friends programs has inherent risks that may result in injury. I acknowledge and accept this fact and agree to hold harmless True Friends, its employees, and agents. I acknowledge that sessions will take place in both individual and group environments.

___ Yes _____
Signature Date

Release of Information Authorization

In order to provide the best services, True Friends may need to obtain information from you or share information with other individuals, programs, or providers. Without your permission to release information True Friends may not be able to provide the services needed or True Friends' assistance may be hindered. The below information meets the requirements of the federal Data Privacy and HIPPA regulations.

I (representing myself or applicant's legal guardian) request and authorize True Friends to receive and disclose information needed to provide services to the applicant from the following parties:

- Applicant
- Case manager and other county personnel
- Residential providers
- Applicant's legal guardian
- Department of Human Services
- Medical personnel including primary doctor, psychologist, psychiatrist

I know that state and federal laws protect my/applicants records. I understand:

- Why I am being asked to release this information
- I do not have to consent to the release of information.
- If I do not consent the information will not be released unless the law otherwise allows it.
- I may stop this consent with written notice at any time but this written retraction will not affect information True Friends had already released.
- The person or agency receiving my information may be able to pass it on to others.
- If my information is passed on to others by True Friends, it will no longer be protected by this authorization.
- This consent will end one year from the signed date.

Signature Date

Liability Release

I, in consideration of being permitted to use the facilities and services of True Friends for their/himself/herself, spouse, my minor child, legal representatives, heirs and assigns, hereby releases, True Friends, (herein called releasee) their officers, members, agents, representatives, heirs and assigns, for any and all loss or damage, and any claim of damages resulting there from on account of injury to releasor's person, even injury resulting in death of the releasor, whether caused by the negligence of releasor or otherwise while the releasor is riding, working, or for any purpose using the facilities, equipment or services of true friends.

- 1.) I agree to indemnify True Friends and their officers, members, agents, employees or volunteers from any loss, damage or cost that may incur due to the participation or use of the facilities, equipment and services of Releasee due to the presence of myself or my minor child in or upon the property owned, located at or controlled by True Friends whether caused by the negligence of the Releasees or otherwise.
- 2.) I fully understand any involvement with horses involves some risk of harm or injury to myself, my minor child, my horses or my other property and that risk of damage or injury is a normal incident of involvement with horse-related activities, and I hereby agree that risk is borne by me and/or my minor child and not by True Friends or their officers, members, agents, employees or volunteers.

***Please Choose:**

___ **Consent Plan**

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

___ **Non-Consent Plan**

I do not give my consent for emergency medical treatment/aid in the case of illness or injury during the process of receiving services or while being on the property of the agency. In the event emergency treatment/aid is required, I wish the following procedures to take place:

This release contains the entire agreement between the parties hereto and the terms of this release are contractual and not a mere recital. I have carefully read the foregoing release and know the contents thereof and signed this release as my own free act.

Signature Date

Participant Name: _____ Date of Birth: _____

Release and Authorization for Use of Photographs, Images, Video and/or Sound Recordings

I hereby grant True Friends and all of its subsidiaries, the irrevocable right and permission, throughout the world, in connection with the photograph(s), images, video or sound recordings that were taken of me by, or which I provided to, True Friends the following: the right to use and reuse, in any manner at all said photographs, images, video, and/or sound recordings in whole or in part, modified or altered, either by themselves or in conjunction with other photographs, images, video and/or sound recordings, in any medium or form of distribution, and for any purposes whatsoever including, without limitation, all promotional, marketing and advertising uses, and other trade purposes, as well as using my name in connection therewith, if True Friends so desires. This permission is granted in perpetuity.

I hereby forever release and discharge True Friends from any and all claims, actions and demands arising out of or in connection with the use of said photographs, images, video and/or sound recordings including, without limitation, any and all claims for invasion of privacy and libel. This release shall inure to the benefit of the assigns, licensees and legal representatives of True Friends.

Participants/Guardian on behalf of Participant: Please check your preferred option.

Yes. I agree to allow True Friends to use photograph(s), images, video, or sound recording as stated above.

No. I do NOT allow True Friends to use photograph(s), images, video, or sound recording as stated above.*

** Please note by stating no, the participant will NOT be featured in group, or activity photos during their stay. They will not be featured through the True Friends website, social media, or other communication mediums.*

Signature Date

Medication Administration and Emergency Medical Authorization

Please review and sign to provide your understanding of the information below. To read the full policy visit www.truefriends.org/policies-procedures.

I authorize staff trained by the program to provide medication assistance, setup and/or medication administration (prescription medications, including psychotropic medications and injectable medications, and over-the-counter medications) or treatments to me ordered for me by a health care professional.

Yes, I agree.

No, I refuse*. *If you refuse, True Friends is unable to serve you. Your application will be returned, and registration will be cancelled.

I authorize the program to act in a medical emergency when the person or the person's legal representative cannot be reached or is delayed in arriving.

Yes, I agree.

No, I refuse*. *If you refuse, True Friends is unable to serve you. Your application will be returned, and registration will be cancelled.

Person _____
Name
Legal Representative _____
Name Signature Date

Policy Receipt and Signature Information

I have been informed of and provided copies of the following policies and procedures affecting a person's rights under section 245D; visit www.truefriends.org/policies-procedures to learn more. Please call 952.852.0101 to have policies and procedures mailed directly to you.

- Grievance Policy
- Service Suspension
- Service Termination
- Emergency Use of Manual Restraint
- Data Privacy
- Maltreatment Reporting
- Service Recipient Rights

Signature Date

Physical/Sexual/Emotional Abuse	<input type="checkbox"/>	<input type="checkbox"/>	
Blood Pressure Control	<input type="checkbox"/>	<input type="checkbox"/>	
Dangerous to self or others	<input type="checkbox"/>	<input type="checkbox"/>	
Exacerbations of medical conditions (i.e. RA, MS)	<input type="checkbox"/>	<input type="checkbox"/>	

Fire Settings	<input type="checkbox"/>	<input type="checkbox"/>	
Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	
Medical Instability	<input type="checkbox"/>	<input type="checkbox"/>	
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	
PVD	<input type="checkbox"/>	<input type="checkbox"/>	
Respiratory Compromise	<input type="checkbox"/>	<input type="checkbox"/>	
Recent Surgeries	<input type="checkbox"/>	<input type="checkbox"/>	
Substance Abuse	<input type="checkbox"/>	<input type="checkbox"/>	
Thought Control Disorders	<input type="checkbox"/>	<input type="checkbox"/>	
Weight Control Disorder	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	
Age - under 4 years	<input type="checkbox"/>	<input type="checkbox"/>	
Indwelling Catheters/Medical Equipment	<input type="checkbox"/>	<input type="checkbox"/>	
Medications - i.e. photosensitivity	<input type="checkbox"/>	<input type="checkbox"/>	
Poor Endurance	<input type="checkbox"/>	<input type="checkbox"/>	
Skin Breakdown	<input type="checkbox"/>	<input type="checkbox"/>	

Please provide your professional opinion as to whether or not your patient is a suitable candidate for mounted horseback riding activities:

Physician's Signature **Date**

Physician's Printed Name

Please send materials to:
True Friends
Attn: Registration
 10509 108th Street NW
 Annandale, MN 55302
registration@truefriends.org

Questions? Please call Customer Relations at 952.852.0101 or email registration@truefriends.org