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: (_____) _____

**We may be unable to accommodate riders who weigh more than 180lbs*

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

Participant Name: _____Date of Birth: _____

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.

___No Diagnosis/Disability/Condition
___Anxiety
___Attention Deficit Disorder
___Autism
___Brain Injury
___Developmental-Cognitive or Intellectual Disability
___***DIABETES – Type 2**
___***EPILEPSY/SEIZURES.** If yes, please provide protocols.
___Fetal Alcohol Spectrum Disorder
___MRSA: ___ Active ___ Inactive
___Multiple Sclerosis (MS)
___***ORTHOPEDIC APPLIANCES**
___Parapalegia
___Prader-Willi Syndrome
___Respiratory
___Spina Bifida
___Tourette Syndrome
___Alzheimer's or Dementia (Beginning Stage)
___Arthritis
___Attention Deficit Hyperactive Disorder
___Bipolar Disorder
___***CATHETER**
___Depression
___Down Syndrome
___Heart Problems, explain: _____
___Muscular Dystrophy (MD)
___ Obsessive-Compulsive Disorder
___Pica
___Parkinson's
___Quadriplegia
___Rett Syndrome
___Sensory Processing Disorder, explain: _____
___***TRACHEOSTOMY**
___Amputee
___Asthma
___Blood Disorder: _____
___Cerebral Palsy
___***DIABETES – Type 1**
___***FEEDING TUBE**
___Oppositional Defiant Disorder
___ Post Traumatic Stress Disorder
___ Pervasive Developmental Disorder
___ Reactive Attachment Disorder
___Williams Syndrome

___Blind ___Vision impaired, no correction ___Wears glasses
___Deaf ___Hearing impaired, no correction ___Wears hearing aid x 1 ___Wears hearing aid x 2
___Left ear ___Right ear
___Uses Sign Language ___Needs a staff proficient in sign language
___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? _____

Participant Name: _____ Date of Birth: _____

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:

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

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

___ Happens "out of the blue" ___ Not getting what he/she wants ___ Unwanted peer interaction
___ Unwanted authoritative interaction ___ 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?: _____
_____
Are you able to wear a mask indoors when not eating or sleeping?: ___ Yes ___ No
Can you socially distance yourself from others during your time at camp?: ___ Yes ___ No
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: _____

Release & Authorization Information

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

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

Participant Name: _____ Date of Birth: _____

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

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

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.

Participant Name: _____ Date of Birth:_____

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

Deposits, 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 credit card login into your account, or include a check with participant name in memo.

_____

Name of Payee Address City State Zip

Cancellation Policy

If for any reason you will be unable to make your scheduled appointment time, a 24-hour notice must be given in order to avoid being charged a no-show fee of one half the cost of a full session (Please note we CANNOT bill the waiver for a missed appointment, such payments are the responsibility of the client themselves). 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. 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.

True Friends
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Annandale, MN 55302
registration@truefriends.org
952.852.0101

To be completed by a physician/health care professional.

Contraindications to Hippotherapy

Dear Health Care Provider,
Your patient 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. 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/email indicated above.

Sincerely,

Director of Therapy and Adaptive Riding

Patient Information

Name: _____
First *Middle* *Last*

Date of Birth: _____ Age: _____ Weight: _____ Height:_____

Primary Diagnosis:
_____
_____

Orthopedic	NO	YES	COMMENTS
Atlantoaxial Instability - include neurologic symptoms	☐	☐	
Coxa Arthrosis	☐	☐	
Cranial Deficits	☐	☐	
Heterotopic Ossification/Myositis Ossificans	☐	☐	
Joint subluxation/dislocation	☐	☐	
Osteoporosis	☐	☐	
Pathologic Fractures	☐	☐	
Spinal Joint Fusion/Fixation	☐	☐	
Spinal Joint Instability/Abnormalities	☐	☐	
Neurologic	☐	☐	
Hydrocephalus/Shunt	☐	☐	
Seizure	☐	☐	
Spina Bifida/Chiari II malformation	☐	☐	
Tethered Cord/Hydromyelia	☐	☐	
Medical/Psychological	☐	☐	
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	☐	☐	
Weight Control Disorder	☐	☐	
Other	☐	☐	
Age - under 4 years	☐	☐	
Indwelling Catheters/Medical Equipment	☐	☐	
Medications - i.e. photosensitivity	☐	☐	
Poor Endurance	☐	☐	
Skin Breakdown	☐	☐	

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