NARHA
North American Riding for the Handicapped Association
PREMIER ACCREDITED CENTER

The Leaning Post Ranch

A Project of
Panhandle Youth Assistance Program, Inc.
4150 Cedar Springs Road
Molino, FL 32577
Phone: 850-587-5940
Fran Gersin, CAAPII and Newman Gersin, CAAPII, Co-Executive Directors

PARTICIPANT PACKET

Enclosures: (These forms are valid for ONE year only.)

1. **Release and Hold Harmless Agreement****
2. **Authorization for Emergency Medical Treatment****
3. **Participant's Medical History & Physician's Statement****
4. **Photo Release****
5. **HIPAA (Health Insurance Portability and Accountability Act) Statement****
6. **Participant's Application & Health History****
7. **Participant's Code of Conduct****
8. **Parent/Guardian's Questionnaire**
9. **Riding Session Policy**
10. **Participant's Dress Code**

** **NO ONE CAN RIDE WITHOUT THESE DOCUMENTS SIGNED AND DATED AND RETURNED TO The Leaning Post Ranch.**

PLEASE READ, COMPLETE, SIGN, DATE, AND RETURN

Updated for the year 2010 to conform to the latest NARHA Standards & Accreditation Manual

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RELEASE AND HOLD HARMLESS AGREEMENT

WHEREAS the UNDERSIGNED acknowledges the inherent risks involved in riding and/or working around horses, which risks include bodily injury from riding, or being in close proximity to horses, among other risks, and further, that both horse and rider/volunteer can be injured in normal use or in competition and schooling;

IN CONSIDERATION, therefore, for the privilege of riding and/or working around horses at **The Leaning Post Ranch**, a project of Panhandle Youth Assistance Program, Inc. (PYAPI), the UNDERSIGNED does hereby **agree** to hold harmless and indemnify **The Leaning Post Ranch** (PYAPI), its Board of Directors, Instructors, Staff and Volunteers, and further release them from any liability or responsibility for any accident, damage, injury, or illness to the UNDERSIGNED or any horse owned by the UNDERSIGNED or to any family member or spectator accompanying the UNDERSIGNED on the premises of **The Leaning Post Ranch** (PYAPI).

UNDER FLORIDA LAW, an equine activity sponsor or equine professional is not liable for an injury to, or the death of, a participant and/or volunteer in equine activities resulting from the inherent risks of equine activities.

DATE: _____

SIGNATURE: _____
(Participant or Parent/Legal Guardian or Volunteer)

Name: _____
(PLEASE PRINT CLEARLY)

Address: _____

Phone #: _____

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Co-Executive Directors
Newman Gersin
CAAPII

Fran Gersin
CAAPII

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Authorization for Emergency Medical Treatment Form

❑ Participant ❑ Staff ❑ Volunteer

Name: _____ DOB: _____ Phone: _____

Address: _____

Physician's Name: _____ Preferred Medical Facility: _____

Health Insurance Company: _____ Policy #: _____

Allergies to medications: _____

Current medications: _____

In the event of an emergency, contact:

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

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 _____ to:
(Center's Name)

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.

Consent Plan

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.

Date: _____ Consent Signature: _____
Client, Parent or Legal Guardian
Signed in presence of center staff

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.

❑ Parent or legal guardian will remain on site at all times during equine assisted activities
❑ In the event emergency treatment/aid is required, I wish the following procedure to take place:

_____

_____

_____

Date: _____ Consent Signature: _____
Client, Parent or Legal Guardian
Signed in presence of center staff

Participant's Medical History & Physician's Statement

Participant: _____ DOB: _____ Height: _____ Weight: _____

Address: _____

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: _____

_____

Mobility: Independent Ambulation Y N Assisted Ambulation Y N Wheelchair Y N

Braces/Assistive Devices: _____

For those with Down Syndrome: AtlantoDens Interval X-rays, date: _____ Result: + --

Neurologic Symptoms of AtlantoAxial Instability: _____

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 _____

Signature: _____ Date: _____

Address: _____

Phone: ( )_____ License/UPIN Number: _____

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PHOTO RELEASE

I, _____
(PLEASE PRINT CLEARLY)

☐ DO

☐ DO NOT

Consent to and authorize the use and reproduction by **The Leaning Post Ranch** (PYAPI) of any and all photographs and any other audio/visual materials taken of me for promotional material, education activities, exhibitions, or for any other use for the benefit of **The Leaning Post Ranch** (PYAPI) riding programs.

DATE: _____

SIGNATURE: _____
(Participant or Parent/Legal Guardian or Volunteer)

Name: _____
(PLEASE PRINT CLEARLY)

Address: _____

Phone #: _____

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HIPPA STATEMENT

This information has been disclosed to you from records protected by Federal Confidentially Rules (42 CFR Part 2 and 42 USC).

The Federal Rules prohibit you from making any further disclosures of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or is otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical and/or other information is not sufficient for this purpose. The Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse client.

I understand the HIPPA information provided, and confidentiality, as **The Leaning Post Ranch** (PYAPI) requires, and I agree to comply with the policies and information as provided.

DATE: _____

SIGNATURE: _____
(Participant or Parent/Legal Guardian or Volunteer)

Name: _____
(PLEASE PRINT CLEARLY)

Address: _____

Phone #: _____

HIPAA

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

SUMMARY

New federal legislation requires the use of standards when sending and receiving certain health information in an electronic format and imposes restrictions on how organizations use, disclose and protect an individual's health information.

While legislators and other officials may communicate with state agencies about constituent health care issues, state agencies may not respond about an individual's protected health information unless the individual constituent has given an authorization to the agency to disclose the information.

You may contact the appropriate agency to obtain an authorization form for constituents to sign.

What is HIPAA?

The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 (HIPAA) was signed into law in August of 1996, and is being implemented in phases. The federal legislation addressed several issues: health care access, portability and renewability; preventing health care fraud and abuse; medical liability reform and *administrative simplification*.

The goals of Title II, Subtitle F - Administrative Simplification (AS) are two-fold. It seeks

1. To improve the efficiency and effectiveness of the health care system through the establishment of standards and requirements for the *electronic transmission* of certain health information, and
2. To protect the security and privacy of health care information by setting standards regarding its use and disclosure.

To meet these goals, HIPAA-AS addresses five specific areas:

Electronic Data Interchange (EDI) – the electronic transfer of information in a standard format between trading partners. Standardization will reduce the administrative costs associated with the exchange of health information among physicians, hospitals and health plans.

Code Sets – data elements used to uniformly document the reasons why patients are seen and what procedures are performed during their visit.

Identifiers – unique numbers used consistently by all parties to identify each health care provider, health plan and employer. In the past, providers had to keep track of multiple identification numbers.

Privacy – establishes a minimum national standard for the protection of individuals' medical records and other personal health information. Honors more stringent state laws regarding the privacy and protection of health information and provides individuals with new health privacy rights, enforceable through the Office for Civil Rights, to ensure consistent protection of health information that is used and stored in providing modern high quality health care.

Security – establishes a national minimal standard to protect the confidentiality, integrity and availability of electronically formatted protected health information. Affected organizations must implement basic safeguards to protect electronic health information from unauthorized access, deletion and transmission.

Who is Affected?

HIPAA requires all **health plans** (e.g.: healt insurance companies, HMOs, Medicare an Medicaid), all **health care clearinghouses** (e.g entities who translate and interpret billin information) and those **health care provide** electronically transmitting certain healt transactions (e.g. claims, eligibility, referral claims status) to comply with its administrativ rules and regulations. HIPAA also extends certa responsibilities for maintaining the privacy ar security of health information to vendors wh perform services on behalf of health plans, healt care providers and health care clearinghouse through arrangements called business associat agreements.

Due to their health care-related activities, the fo lowing state agencies are subject to HIPAA's rul and regulations:

- Agency for Health Care Administration (admi isters Florida's Medicaid program).
- Department of Corrections (provides healt care to inmates).
- Department of Health (provides health ca to clients through county health departmen and Children's Medical Services).
- Department of Children and Families (ope ates hospitals).
- Department of Elder Affairs (administers ca management services for the elderly).
- Department of Veterans' Affairs (operate nursing homes).
- Department of Management Services (the D vision of State Group Insurance manages th State of Florida's self-insured health plan).

When is Compliance Required?

HIPAA's rules and regulations are being written by the federal department of Health and Human Services and have been released at different times and have different compliance dates. The rules may be amended on an annual basis. Key compliance dates include:

April 14, 2003 - Compliance with the privacy rule requirements.

October 16, 2003 - Compliance with the transactions and code sets requirements.

July 30, 2004 - Compliance with the unique employer identifier standard.

April 21, 2005 - Compliance with the security rule requirements.

What are the Penalties?

The Centers for Medicare and Medicaid Services (CMS) will be responsible for enforcing the transactions and code sets standards and security standards, while the Office for Civil Rights (OCR) will enforce the privacy standards. OCR has indicated that enforcement will be complaint-driven. The Department of Health and Human Services and its Office for Civil Rights will contact entities and attempt to settle complaints through voluntary compliance. However, willful or repeated violations of HIPAA AS rules and regulations could result in civil monetary penalties or criminal penalties.

The civil penalty for failing to comply with a transaction, code set or identifier rule requirement is:

- Each violation: $100.
- Maximum penalty for all violations of an identical requirement may not exceed $25,000 annually.
- Violations of several different requirements may result in penalties greater than $25,000.

Wrongful disclosure of health information is subject to criminal penalties:

- Wrongful disclosure offense: up to $50,000 fine and one year imprisonment
- Offense under false pretenses: up to $100,000 and five years imprisonment
- Offense with intent to profit: up to $250,000 and ten years imprisonment

For More Information

Department of Health & Human Services HIPAA-AS
http://aspe.os.dhhs.gov/admnsimp/

Office for Civil Rights HIPAA - Privacy
http://www.hhs.gov/ocr/hipaa/

Centers for Medicare & Medicaid Services HIPAA-AS
http://www.cms.hhs.gov/hipaa/hipaa2/default.asp

Workgroup for Electronic Data Interchange
http://www.wedi.org/

HIPAA (Government Information Value Exchange for States) GIVES
http://www.hipaagives.org/

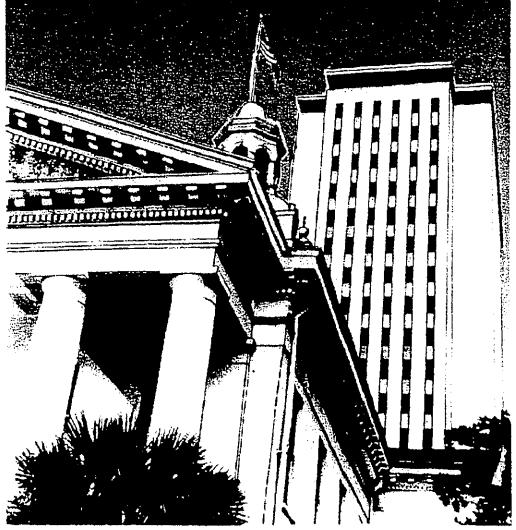
National Governors Association Center for Best Practices - HIPAA
http://www.nga.org/center/topics/1,1188,D_4324,00.html

Florida's State Technology Office - HIPAA
http://www.myflorida.com/myflorida/sto/hipaa/index.html

Florida Medicaid Program - HIPAA
http://www.fdhc.state.fl.us/Medicaid/hipaa/index.shtml

HIPAA

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT



MyFlorida.com

State Technology Office
State of Florida

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Participant's Application and Health History

GENERAL INFORMATION

Participant: _____

DOB: _____ Age: _____ Height: _____ Weight: _____ Gender: M F

Address: _____

Phone: _____ E-mail_____ Alternative #: _____

Employer/School: _____

Address: _____

Phone: _____

Parent/Legal Guardian: _____

Address (if different from above): _____

Phone: _____

Referral Source: _____

Phone: _____

How did you hear about the program? _____

HEALTH HISTORY

Diagnosis _____ Date of Onset:_____

Please indicate current or past special needs in the following areas:

	Y	N	Comments
Vision			
Hearing			
Sensation			
Communication			
Heart			
Breathing			
Digestion			
Elimination			
Circulation			
Emotional/Mental Health			
Behavioral			
Pain			
Bone/Joint			
Muscular			
Thinking/Cognition			
Allergies			

(over)

MEDICATIONS *(include prescription, over-the-counter; name, dose and frequency)* _____

Describe your abilities/difficulties in the following areas (include assistance required or equipment needed):

PHYSICAL FUNCTION (i.e. Mobility skills such as transfers, walking, wheelchair use, driving/bus riding)

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?)

Signature: _____ Date: _____

PHOTO RELEASE

I ❑ DO
❑ DO NOT
consent to and authorize the use and reproduction by _____ (center)
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 program.

Signature: _____ Date: _____
Client, Parent or Legal Guardian
Signed in the presence of center staff

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PARTICIPANT'S CODE OF CONDUCT

MAKE THE RIGHT CHOICE!

- ✓ STAY SAFE – Obey all the rules and follow directions
- ✓ SPEAK IN NORMAL TONE – Don't yell
- ✓ ONLY ENTER ARENA WEARING HELMET
- ✓ ONLY ENTER ARENA WITH INSTRUCTOR
- ✓ FOLLOW SAFETY RULES NEAR HORSES
- ✓ RESPECT ALL STAFF, STUDENTS, AND HORSES

CONSEQUENCES OF WRONG CHOICE!

- ✓ VERBAL WARNING
- ✓ TIME OUT
- ✓ SUSPENDED FROM NEXT LESSON
- ✓ SUSPENDED FROM PROGRAM

DATE: _____

SIGNATURE: _____
(Participant or Parent/Legal Guardian or Volunteer)

Name: _____
(PLEASE PRINT CLEARLY)

Address: _____

Phone #: _____

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PARENT/GUARDIAN QUESTIONNAIRE

RIDER' NAME: _____

We appreciate the opportunity to teach your child to horseback ride and would Like your input to make it a more enjoyable experience. Please complete the following information:

What are your expectations and goals for your rider? _____

_____

Do you want or need to be involved with your rider's sessions? If so, please explain.

_____

_____

Would you like your rider to be involved in special events? If so, please check all that apply.

- ☐ Special Olympics *
- ☐ Family Days
- ☐ Publicity shots or photos
- ☐ Horse Shows
- ☐ Parades
- ☐ Speaking engagements

* Requires background investigations for volunteers and coaches.

Do you want to volunteer in our special events? If so, please check all that apply.

- ☐ Providing refreshments
- ☐ Coordinating riders and/or volunteers
- ☐ Sponsorship of events (you and/or your office)
- ☐ Decorating
- ☐ Fundraising
- ☐ Assisting riders and/or horses (side walking, tacking horses, etc.)

Thank you for your assistance!

DATE: _____

SIGNATURE: _____
(Participant or Parent/Legal Guardian or Volunteer)

Name: _____
(PLEASE PRINT CLEARLY)

Address: _____

Phone #: _____

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PLEASE READ, AND THEN KEEP THE PAGES THAT FOLLOW FOR YOUR OWN FILES

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RIDING SESSION POLICY

Due to time limitations, and our program expansion resulting in additional need for our services, **The Leaning Post Ranch** ***requires*** **24 hour** advanced notice of session cancellation for **ALL** riders.

If **The Leaning Post Ranch** has to cancel sessions due to our limited number of instructors and/or available staff and volunteers, riders will be notified at least 24 hours in advance.

The Leaning Post Ranch ***will*** cancel ***all*** sessions when there is severe weather and/or lightning.

If you have questions or need to cancel a session, please call **The Leaning Post Ranch AND** your instructor at the phone numbers listed below:

The Leaning Post Ranch: # 850-587-5940

YOUR INSTRUCTOR: _____

Phone #: _____

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PARTICIPANT'S DRESS CODE

For **SAFETY** reasons **all** riders must come dressed appropriately for riding and/or working with horses. Proper attire is as follows:

- Jeans or long pants to protect legs from rubbing against saddle
- Boots, hard soled closed toe shoes with a heel, or sneakers – NO SANDALS!
- American Society for Testing and Materials – Safety Equipment Institute (ASTM-SEI) approved riding helmet (provided by **The Leaning Post Ranch** or your own approved riding helmet).

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