The Medicine Horse Center
Therapeutic Riding & Equine Rehabilitation
P.O. Box 1074, Mancos, CO 81328
Tel: 970-533-7403 Fax: 970-533-7405

Application for Waiver of Participant Fees

Participant Name:____

DOB: ____________________ **Social Security #**: ______________________________

Parent/Legal Guardian Name: (*if participant is under 18 years of age*)

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Parent/Guardian DOB: _____________ ***Social Security #*:** _______________________

Mailing Address:____

City: ____________________________________ **State**: ________ **Zip**: ___________

Telephone: Day: _________________________ Eve:___________________________

Participant Employer or School: ____

Parent/Guardian Employer: ____

Annual Household Income: *(Please include all sources of income):* $______________

Number of Dependants in Family: _________________

CONSENT FOR RELEASE OF INFORMATION

I, ______________________________________hereby authorize and request that the
(client or parent/guardian)
following may release pertinent information regarding participant suitability for equine assisted therapies, to ***The Medicine Horse Center, P.O. Box 1074, Mancos, CO 81328***:

School: ____________________________________

Primary Physician: __________________________________

Primary Therapist: __________________________________

In order to participate in The Medicine Horse Center: Equine Assisted Therapies Program, I would like to apply for a partial or full waiver of participant fees. As a condition for applying for financial assistance, I understand that the school, physician, therapist listed may be contacted by The Medicine Horse Center. I also understand that the only qualification for a waiver of fees is an inability to pay.

THE NUMBER OF SCHOLARSHIPS AVAILABLE IS DEPENDENT UPON THE GENEROSITY OF THOSE WHO DONATE TO THE MEDICINE HORSE CENTER. SCHOLARSHIPS ARE NON-TRANSFERABLE.

Please describe your circumstances affecting your ability to pay:

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Please describe any other financial assistance from which you may be able to receive to assistance (family, church, employer, etc.):

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How do you see the Medicine Horse Center helping you/your child?

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Signed: ____Date: _________________
(Participant or Parent/Legal Guardian)

Print Name: ____
(Participant or Parent/Legal Guardian)

OFFICE USE ONLY:

Participant Name:____

Approval Date: ________ Amount: _________ Funded by:____________________

Recipient Notified: __________________ Date: _____________