



April 1, 2010

Dear Friends of Citizens with Disabilities:

The Pony Express Horseback Riding Program is now registering for our 2010 Spring Session. We are very excited about being able to offer this beneficial program for children and young adults with disabilities in Licking County.

Formal programs for horseback riding for individuals with disabilities have been organized since 1953 in England and since 1969 in the United States. Locally, the Licking County Equestrian Center has donated the use of their facility for our local riding program under the Friends of Citizens with Disabilities.

Riding is an excellent form of therapeutic recreation and socialization. Riding helps to develop self-awareness, self-confidence, and self-discipline. It also strengthens and relaxes muscles, improves posture, balance, coordination, while also increasing joint mobility.

Classes will be filled on a first-come, first serve basis. **In order to reserve your space, registration forms and payment must be returned by April 12, 2010.** Riding sessions will be held April 27 – June 1, 2010 on Tuesday evenings, beginning promptly at 6:00 p.m.

If you have questions, please contact Lisa Baker at 345-9861 or lbaker@goodwillnewark.com

Sincerely,

Lisa Baker
Communications Administrator
Licking/Knox Goodwill Industries, Inc.
Friends of Citizens with Disabilities



Pony Express Rider's Fact Sheet

Who Can Enroll?

All individuals with disabilities in Licking County may participate. Adult participation is based on space availability. Participant's eligibility is based on space, safety, and suitability of the rider to the program.

When are the Sessions?

April 27 – June 1, 2010, all sessions will be held on Tuesday evening and begin promptly at 6:00 p.m. Water will be available at each session.

Where are the Sessions Held?

Licking County Equestrian Center
12450 Flint Ridge Road
Newark, Ohio 43055

What is the Cost of the Program?

\$20.00 per rider per 6 week session
Make checks payable to: Friends of Citizens with Disabilities

How do I Enroll?

Return registration forms and payment to:

Friends of Citizens with Disabilities
Attention: Pony Express Program
P.O. Box 46
Newark, OH 43058-0046

What Else do I Need to Know?

- Space is limited participants are enrolled first come first serve. Payment and forms must be returned to reserve your space.
- You will be contacted by phone to confirm your enrollment.
- INCLEMENT WEATHER – We will make every attempt to reach you at the number provided to inform you of any cancellations due to inclement weather.



Liability Waiver

I hereby for myself, and for my child or ward if signed by a parent or guardian, waive any and all claims against Friends of Citizens with Disabilities and/or the Pony Express Riding Program, their agents, volunteers, or employees for any and all injuries or damages suffered in relation to equine activities. I acknowledge that equine activities involve certain inherent risks, including, but not limited to:

- a. The propensity of an equine to behave in ways that may result in injury, death or loss to persons on or around the equine;
- b. The unpredictability of an equine's reaction to sounds, sudden movement, unfamiliar objects, persons, or other animals;
- c. Hazards, including, but not limited to, surface or subsurface conditions;
- d. A collision with another equine, another animal, a person or an object; and
- e. 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.

I further acknowledge that reasonable inquiry was made regarding my (or my child's or ward's if signed by a parent or guardian) experience with equines including the ability to safely engage in equine activities and to safely manage an equine.

Date: _____

Participant/Volunteer Signature (parent if a minor)

Participant's Printed Name

Complete & Return

LICKING COUNTY EQUESTRIAN CENTER

12450 Flint Ridge Road SE

Newark, OH 43056

740/349-4663 (hoof)

WAIVER OF LIABILITY

I understand that equine activities are inherently dangerous and that there are obvious and non-obvious risks. In exchange for my participation in equine activities, I accept those risks. I release the Licking County Equestrian Center ("LCEC") and anyone associated the LCEC including but not limited to owners, trainers, and guests from liability due to ordinary negligence. I shall bring no claims, demands, actions and causes of action and/or litigation, against LCEC or anyone associated with LCEC for any economic or non-economic losses due to bodily injury, death, or property damage sustained by me and/or my minor child or legal ward and/or my horse in relation to LCEC, its premises or operation, while riding, handling, observing, or otherwise participating in equine activities. Further I shall indemnify and hold LCEC harmless for any such actions filed by my minor child, my guest or anyone under my control or at LCEC at my invitation.

Date: _____
Equine Activity Participant/Volunteer (parent if a minor)

Witness: _____
Printed Name

Complete & Return



Contact Information Form

Participant Information:

Participant's Name: _____

Date of Birth: _____

Nature of Disability: _____

T-Shirt Size: _____

Parent Information:

Parent/Guardian Name: _____

Home Phone: _____

Parent Work Number: _____

Email Address: _____

Home Address: _____

City: _____ State: _____ Zip: _____

T-Shirt Size: _____

Session Cancellations for Inclement Weather

Phone Number where we can reach you or leave a message during the day.

Phone Number

Complete & Return



Rules For Horseback Riding Classes

Helmets are to be worn by riders at all times.

Long pants or jeans, sturdy boots or shoes are recommended for riders and volunteers.

Only rider, volunteers and instructors are allowed in the riding area.

Participants who require lifting - Volunteers may not be able or willing to lift participants. In order to ensure that the participant will ride each evening, please be prepared to assist your child or bring someone to assist at the sessions.

Parents are responsible for the supervision of their children outside the riding arena.

All forms and payment must be completed and returned PRIOR to the first session.

- A) Emergency medial form
- B) Friends of Citizens with Disabilities Waiver of Liability
- C) Photo release
- D) Rules for horseback riding classes
- E) Licking County Equestrian Center Waiver of Liability
- F) Contact Information Form

No smoking at any time in the barn area.

Only individuals who have completed the necessary paperwork and have made payment will be allowed to ride or participate in the program.

Parents/guardians are encouraged to assist the Pony Express volunteers as they work with your child/participant.

I have read and understand the rules for the Pony Express Horseback Riding Classes.

Participant Name: _____

Parent/Legal Guardian: _____ Date: _____

Complete & Return

**FRIENDS OF CITIZENS WITH DISABILITIES
EMERGENCY MEDICAL AUTHORIZATION**

Name: _____ Date of Birth: _____

Address: _____ Phone: _____ (h)

Phone: _____ (c)

IN THE EVENT THAT EMERGENCY MEDICAL TREATMENT IS NECESSARY, PLEASE CONTACT:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Physician: _____ Phone: _____

Dentist: _____ Phone: _____

MEDICATION:

Medicine Name	Dose	Schedule	Reason Prescribed

Check box & continue medicine on back if necessary

Known Allergies: _____

Medical Conditions: (Diabetes, Heart Disease, Epilepsy, Etc.)

Over the Counter Medications:

Aspirin:

YES
 NO

Non-Aspirin:

YES
 NO

Antacids:

YES
 NO

Cold/Allergy:

YES
 NO

Employee Signature

Date

Form Completed By

Relationship

3/97 – Policy:G3.8, VR16.2
Reviewed/Revised 11/98,11/05, 5/06, 11/09

Complete & Return



Public Relations Photo Release

I, _____, agree to allow my name, photo and information about me to be used to promote Friends of Citizens with Disabilities.

Yes No Friends of Citizens with Disabilities may use my photo to promote the Pony Express Riding Program. (To be seen by the public.)

Yes No Friends of Citizens with Disabilities may use my photo for websites, newsletters, promotional publications, or other types of recognition. (To be seen by the public.)

Signed: _____ Date: _____

Witnessed: _____ Date: _____

I may revoke my permission at any time by signing this section:

Signed: _____ Date: _____

Witnessed: _____ Date: _____

Complete & Return

FRIENDS OF CITIZENS WITH DISABILITIES, INC.
NOTICE OF PRIVACY PRACTICES
Effective: April 14, 2003

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE
USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS
INFORMATION**

PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact the Human Resource Administrator at the Administrative Office (740-345-9861).

WHO WILL FOLLOW THE REQUIREMENTS OF THIS NOTICE

This notice describes Licking Knox Goodwill Industries, Inc.'s practices and those of:

- Any health care professional authorized to share medical information with us regarding you.
- All departments and units of the agency.
- All employees, staff and other agency personnel.
- All of the following entities, sites, and locations comply with the terms of this notice. In addition, these entities, sites and locations may share medical information with each other for treatment, payment, or agency operations purposes described in the notice.
 1. Licking County Board of MRDD
 2. Ohio Bureau of Vocational Rehabilitation
 3. Ohio Bureau of Services for the Visually Impaired
 4. School Systems
 5. Licking County Department of Job and Family Services
 6. Community Mental Health and Recovery Board Agencies
 7. Court Systems
 8. Social Security Administration

OUR PLEDGE REGARDING MEDICAL INFORMATION:

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the services you receive at the agency. We need this record to provide you with quality support and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the agency, whether made by agency personnel or staff under contract to the agency.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

- Assure medical information that identifies you is kept private;
- Give you this notice of our legal duties and privacy practices with respect to medical information about you; and
- Follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

- **For Supported Employment Services** We may use medical information about you to provide you with quality support services during your employment with this agency. For example, we may design a modified work schedule or area to accommodate a diagnosed medical condition that may not permit you to work in a full capacity. We may share this information with your direct supervisors so that they are aware of your condition and can provide you with support. Different departments of the agency may share medical information about you to coordinate the different things that you may need such as prescriptions, counseling or other support services.
- **For Vocational Rehabilitation Programs** We may use medical information about you to design and implement a quality rehabilitation program for you. We may share medical information about you with staff within the agency in order to provide you with the support services necessary to make this program effective. We may also share medical information about you with other professionals outside of the agency who may be involved in your overall care. For example, we may need to update a referring counselor on your progress and any barriers to progress that we may have encountered.
- **For Community Service Programs** We may use medical information about you while you participate in a community service program within our agency. For example, we receive medical information from the Juvenile Court System for juveniles referred to Licking/Knox Goodwill Industries, Inc. for a community work program. We keep this information on file in case of an emergency.
- **For Recreational Programs** We may keep medical information about you for a recreational program operated by a sister agency (Friends of Citizens with Disabilities). This information may be shared with a contracted program coordinator for the purpose of operating the program in a safe manner.
- **For Payment** We may use and disclose medical information about you so that the services you receive at Licking/Knox Goodwill Industries, Inc. may be billed for. For example, we may need to give various State Departments information about services you received at the agency so that they can pay us for those services.
- **Health-Related Benefits and Services** We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.
- **Individuals Involved in Your Care or Payment for Your Care** We may release medical information about you to a friend or family member who is involved in your care. We may also give information to someone who helps pay for your care.
- **Required By Law** We will disclose medical information about you when required to do so by federal, state, or local law.
- **To Avert a Serious Threat to Health or Safety** We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.
- **For Marketing** We may use and disclose medical information about you for purposes of promoting a service provided by the agency. For example, we may use a brochure with

your picture or testimonial showing how our services helped you obtain training services or employment.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

You have the following rights regarding medical information we maintain about you:

- **Right to Inspect and Copy** You have the right to inspect and copy medical information that may be used to make decisions about the services provided to you by Licking/Knox Goodwill Industries, Inc. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Human Resource Administrator. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy medical information in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. The Director of Administration, Director of Operations, and/or the Executive Director will review your request and the denial. The person conducting the review will not be the person who denied your request.
- **Right to Amend** If you feel that medical information we have about you is incorrect or incomplete you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by, or for, the agency. To request an amendment, your request must be made in writing and submitted to the Human Resource Administrator. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:
 1. Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
 2. Is not part of the medical information kept by or for the agency;
 3. Is not part of the information which you would be permitted to inspect and copy;
or
 4. Is accurate and complete.
- **Right to an Accounting of Disclosures** You have the right to request a 'accounting of disclosures'. This is a list of the disclosures we made of medical information about you. To request this list or accounting of disclosures, you must submit your request in writing to the Human Resource Administrator. Your request must state a time period that may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate what form you want the list (for example, on paper, electronically, etc.). The first list you request within any 12-month period will be free. For additional lists, within that 12-month period, we may charge you a fee. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.
- **Right to Request Restrictions** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a treatment that you had. **We are not required to agree to your request.** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your

request in writing to the Human Resource Administrator. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

- **Right to Request Confidential Communications** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. This request, however, has to be in reasonable terms. For example, you can ask that we only contact you at home or by mail. To request confidential communications, you must make your request in writing to the Human Resource Administrator. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests.
- **Right to a Paper Copy of This Notice** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice by calling the administrative office at 740-345-9861 and asking that a copy be sent to you. You will need to leave your name and a current mailing address.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in the administrative office in Newark, Ohio. The notice will contain on the first page in the top center, the effective date. In addition, each time you are employed at or receive services from Licking/Knox Goodwill Industries, Inc., you will be offered a copy of the current notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the agency or with the Secretary of the Department of Health and Human Services. To file a complaint with the agency, contact the Human Resource Administrator, 740-345-9861. All complaints must be submitted in writing.

You will not be penalized or discriminated against for filing a complaint.

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.