

Hippotherapy Program Scholarship Application

Thank you for your interest in the **Hippotherapy Scholarship Program** offered by **White Horse Equine Assisted Services, LLC**. This scholarship is intended to increase access to medically-based hippotherapy services for individuals who demonstrate financial need.

Please complete all sections of this application. Submission of this form does NOT guarantee the award of a scholarship.

Applicant Information

Participant Name: _____

Date of Birth: _____ **Age:** _____

Primary Diagnosis (as documented by a licensed provider):

Parent/Guardian Name (if participant is a minor):

Address:

City, State, Zip:

Phone Number: _____ **Email Address:** _____

Therapy & Program Information

Referring Therapist / Medical Provider (if applicable):

Discipline (check all that apply):

Occupational Therapy Physical Therapy Speech-Language Therapy

Anticipated Start Date of Hippotherapy: _____

Financial Information

Total Annual Household Income:

Under \$25,000
 \$25,000–\$49,999
 \$50,000–\$74,999
 \$75,000–\$99,999
 \$100,000+

Number of Dependents in Household: _____

Are you currently receiving any of the following? (check all that apply):

Medicaid SSI/SSDI State Waiver Services Other

Assistance: _____

Insurance Provider: _____

Does your insurance cover hippotherapy?

Yes No Partially Unsure

Scholarship Request

Amount of Scholarship Assistance Requested (circle one):

- **4 Week Program Period:** 25%- \$120 50%- \$240 75%- \$360 100%- \$480
- **8 Weeks (Two Scheduled Program Periods):** 25%- \$240 50%- \$480 75%- \$720 100%- \$960

Length of Assistance Requested:

One 4-week program period
 Two program periods (8 weeks)

Personal Statement

Please briefly describe your financial need and how participation in the hippotherapy program would benefit the participant. (Attach additional pages if needed.)

Supporting Documentation (Required)

Please attach copies of the following (as applicable):

- Proof of income (recent tax return, pay stub, or benefits statement)
- Therapy prescription or plan of care
- Insurance explanation of benefits (if available)

Acknowledgment & Consent

I certify that the information provided in this application is true and complete to the best of my knowledge. I understand that providing false or misleading information may result in denial or termination of scholarship assistance.

I acknowledge that scholarship awards are subject to availability of funds and program appropriateness.

Signature (Parent/Guardian or Participant): _____

Printed Name: _____ **Date:** _____

Submission Instructions

Please submit this completed application and all supporting documentation to:

White Horse Equine Assisted Services, LLC

Email: whitehorseequineservices@gmail.com

Applications are reviewed on a rolling basis. Applicants will be notified of decisions once review is complete.

White Horse Equine Assisted Services, LLC reserves the right to modify or discontinue the scholarship program at any time.