Florida Thoroughbred Horsemen's Association, Inc.

Application for Assistance Form

All requests for financial assistance from the Florida Thoroughbred Horsemen's Association will be submitted and evaluated by the Benevolence Committee. The process takes approximately 3 weeks upon receipt of a completed request form. This form must be filled out completely to be considered for financial assistance. **An incomplete application will not be processed.**

To be considered for financial assistance applicants must be on a trainer's badge list employed on the Gulfstream Park or Palm Meadows backstretch for at least 120 days and hold a current Florida license.

The following supporting documents must be submitted with this application:

•Copy of current Florida license

•Formal letter detailing specific need for financial assistance

•Copy of last four (4) payroll/workers' compensation/disability stubs

•Copy of previous year's W-2 statement

•Copy of invoice/bill you are requesting assistance with

• If you are requesting mortgage or rent assistance, you must include a copy of your mortgage/lease agreement last four (4) rent/mortgage payments. If you do not have a lease agreement, you must provide the name, address and telephone number of your current landlord.

Upon completion, please return the form for processing to:

FTHA

P. O. Box 3507

Hallandale, FL 33008

If you have any questions, please contact the FTHA Office at (954) 457-3516.

FLORIDA THOROUGHBRED HORSEMEN'S ASSOCIATION APPLICATION FOR ASSISTANCE

P. 0. Box 3507
Hallandale, FL
33008
Telephone: (954) 457-3516 • Fax: (954) 457-3517

Date:________________________

Name:____ Date of birth: _____________________

Address: ____

City: __________________________ State: _________________ Zip Code: ________________

Email Address: ___________________________ Mobile Telephone: _______________________

Social Security Number: ____________________ Marital Status (Circle One): Single Married Divorced

Spouse's Date of Birth:_______________

Dependent's Name Relationship

1.__________________________ _______________

2.__________________________ _______________

3.__________________________ _______________

License #: ____________________________ Position: ____

Employer ___________________________ Employer's telephone number: _______________________

Gross weekly/ Bi-weekly salary: _______________ Length of time with present employer: _________

List last two employers and dates employed with them: ____

Years employed on Gulfstream/Pal Meadows backstretch: _______________________________________

Are you currently employed by anyone else? _________ Name of 2nd employer: ___________________

Gross weekly salary with 2nd employer? ____

Other Income (explain): ____

Spouse's employer:____ Gross weekly salary: ________

(Include a copy of spouse's W-2 statement)

Does your spouse have medical coverage?____________ Name of carrier: ________________________

Are you covered under spouse's medical insurance?____________________

Medical insurance ID#___________________Medical insurance carrier's phone # __________________

What type of assistance are you requesting? ____

If this is a medical bill, has claim been submitted to insurance company?_____________When?________

Itemize outstanding medical bills, list provider and amount owed:
(Attach copies of bills and explanation of benefit statement from insurance carrier)

_______________________________________ $____________________________

_______________________________________ $____________________________

_______________________________________ $____________________________

Are you collecting any disability payments? [] yes [] no If yes, amount: ____________________

Date you started collecting disability payment:________________ Date you can return to work: _________

Was accident work related? [ ] yes [ ] no Date of accident: _______________

Has Workers' Compensation Insurance been filed? [ ] yes [ ] no

Date Filed:_______________ (please provide proof of filing)

Are you collecting compensation payments? [ ] yes [ ] no Amount?_____________

Are you receiving assistance from any other source [ ] yes [ ] no If yes, please list source and amounts:

_______________________________________ $____________________________

_______________________________________ $____________________________

Are you presently under the care of a physician? [] yes [] no

If yes, please attach a letter or note from your physician specifying when you are able to return to work.
(Please note additional documentation may be required)

Name of physician: _________________________ Telephone number: _______________________

Do you [ ] own [ ] rent your home:____________________ Monthly payment:__________________