NYTHA, INC.
APPLICATION FOR ASSISTANCE

In order to be considered for assistance through the New York Thoroughbred Horsemen's Association Inc., you must submit a <u>completed Application for Assistance</u> form along with your last four (4) payroll stubs/disability check stubs/compensation check stubs (copies of checks are acceptable), the previous years' W-2 statement and a copy of your current NYRA badge.

You must be on a trainer's badge list and employed on NYRA backstretch for at least 180 days.

NEW YORK THOROUGHBRED HORSEMEN'S ASSOCIATION, INC
APPLICATION FOR ASSISTANCE

P. O. Box 170070
Jamaica, NY 11417
Aqueduct 718 848-5045 • fax 718 848-9269 • Belmont 516 488-2337 • fax 516 488-1698

Date: _____

Name: _____ Date of birth: _____

Address: _____

_____

Home Telephone #: _____ Barn/mobile telephone #: _____

Social Security Number: _____

Martial Status: ☐ Single ☐ Married ☐ Divorced ☐ Other Spouse's Date of Birth: _____

Dependents	Relationship	Ages
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

Badge/Pinkerton I.D. #: _____Position: _____

Employer: _____ Employer's telephone number: _____

Gross salary per week: _____ Length of time with present employer: _____

List last two employers and dates employed with them: _____

_____

Length of time employed on NYRA backstretch: _____

Are you currently employed by anyone else? _____If yes, with whom? _____

What is you gross salary per week with 2nd employer? _____

Other Income (explain) _____

Spouse's employer: _____ Gross salary per week: _____

(please 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 I.D.# _____ Medical insurance carrier's phone #_____

What type of assistance are you requesting? _____

If this is a medical bill, has backstretch insurance been filed? _____When? _____

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

1. _____ $_____
2. _____ $ _____
3. _____ $ _____
4. _____ $ _____
5. _____ $ _____

Have you met your deductible for the current year? _____

Who is this bill for? _____ Date(s) of service: _____

Is this bill in collections? _____ If yes, as of what date: _____

Are you collecting any disability payments? _____ If yes, amount: _____

Date you started collecting disability payment: _____Date you can return to work: _____

Was accident work related? _____Date of accident: _____

Has Workers' Compensation Insurance been filed? _____ When? _____
(please provide proof of filing)

Is applicant collecting compensation payments? _____Amount? _____

Are you presently under the care of a physician? _____yes _____no

If yes, please attach letter from physician specifying condition, whether or not you are able to work and prognosis.

Name of physician: _____

Telephone number of physician: _____

Do you ☐ own ☐ rent ☐ other (explain) _____ Monthly payment: _____

If you are requesting mortgage or rent assistance, please include a copy of your mortgage/lease, last (4) receipts, name, address and telephone number of mortgage lender/mortgage holder.

Please explain specific need for financial assistance from the NYTHA and attach to application.