CHARLES TOWN HORSEMEN'S ASSISTANCE FUND, INC.

REQUEST FOR ASSISTANCE

GENERAL ELIGIBILITY REQUIREMENTS & REGULATIONS
EFFECTIVE APRIL 1, 2013

1. **MUST**
    a. Have been licensed by the WV Racing Commission as for a minimum of ninety (90) continuance days as an Assistant Trainer, Exercise Rider, Groom, Hot Walker, Pony Rider, Trainer, Owner/Trainer. If you are an **OWNER ONLY**, you are **NOT** Eligible; and
    b. Be in good standing with the WV Racing Commission for a minimum of sixty (60) continuance days; and
    c. Not be eligible for the WBTF; and
    d. Work or be employed at the Charles Town Races complex; and
    e. Have lawful financial need; and
    f. Be able to substantiate need (i.e. provide medical bills to substantiate injury or illness); or
    g. Be widow/widower, spouse or dependent of licensee.
2. No job or low paying job by Applicant is **NOT** need, by itself.
3. Medical bills arising from workmen's compensation situations will **NOT** qualify.
4. Medical bills will **NOT** be considered for payment until applicant applies to the DHHR and the Hospital for benefits first. Proof that you have been turned down for assistance must be submitted with application. Medical bills older than 6 months will not be considered.
    a. DHHR is located at: 239 Willow Spring Drive, Charles Town, WV 25414
    Phone: 304-724-2600 **Fax:** 304-728-0529
    Hours: 8:30 am to 5:00 pm - Monday thru Friday
5. Need is **NOT** defined as a total lack of assets.
6. Need will **NOT** be on a continuing basis.
7. Need can only be for **NECESSITIES**.
8. Assistance will **NOT** be given on a grant or reimbursable basis.
9. Assistance will **NOT** be in the form of cash.
10. Assistance will **NOT** exceed a total of $5,000 per family in a 5year period. Extreme cases may be considered by the board if this is exceeded.
11. Assistance will **NOT** be given for horse business payoffs.
12. Vision Assistance will **NOT** exceed one exam or one set of glasses per beneficiary within a one (1) year period. Upgrading frames or lenses are at the Applicant's expense.
    a. Maximum amount for Exam - $49/person
    b. Single vision glasses including frame - $38/person
    c. Bifocal glasses including frame - $70/person
    d. Dialation $10
13. Burial Assistance will be limited to $3,500 with need being established on an individual basis.
    a. Burial Assistance is available to licensees and their immediate families (spouse and children under the age of 21 still living at home)

b. Burial Assistance is available to former licensees (but not their immediate families) if they were licensed a minimum of 10 years.

14. Cosmetic surgery will **NOT** qualify.

15. Abortions will **NOT** qualify unless caused by rape, incest, or medical necessity.

16. Dental Assistance will **NOT** exceed $1,000 total in a one year period.

17. An Applicant may appear before the board and/or committee to present his/her case.

a. Meetings between Applicant and individual board and/or committee members are **NOT** authorized.

18. No application will be considered unless it is COMPLETELY filled out. Applications that have not included all the information needed will not be considered.

19. Rental or mortgage assistance will not exceed $1,000.00 in one year.

a. You must include a letter from your landlord indicating how much rent is due, rental location, and the time frame the rent covers.

20. Utility assistance will not exceed $500 in a year.

21. No assistance will be given to pay late fees.

22. The Board of Directors and/or Committee members retain final interpretations of all guidelines.

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Revised 12-2015

This form must be completed IN FULL on both sides for consideration by the committee.

A COPY OF YOUR PICTURE BADGE MUST BE ATTACHED.

Date_____

Name:_____
Last First Middle

Address: _____
Street

_____
City State Zip

Home Phone #:_____ Cell Phone #:_____

Licensed as:_____ Years in WV: _____ SS#:_____

Do you carry insurance: _____? Type: _____

YOU MUST LIST ALL EMPLOYERS AND PAY.

FAILURE TO DISCLOSE ALL WILL BE CAUSE FOR DENIAL.

Current employer:_____
How long:_____ Is this a full time job?: _____ Weekly pay: $_____

Current employer:_____
How long:_____ Is this a full time job?: _____ Weekly pay: $_____

Previous employer:_____
How long:_____ Was this a full time job?: _____ Weekly pay: $_____

Who else lives in the household?: _____

Other Income: $_____/Weekly; Earned by?:_____

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Do you rent?: _____; If yes $_____Monthly or $_____Weekly

How much assistance is needed?: $_____

Assistance will be used for: _____

Who will assistance be used to pay? (name of landlord, utility, doctor, etc..)_____

_____

Reason assistance needed: _____

_____

Is this a medical bill? _____YES _____NO; Is it more than 6 months old? If yes, it doesn't qualify for assistance.

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Have you applied to DHHR and the hospital for assistance? ________; If yes, please attach a copy of the DHHR and the hospitals needs determination letter. If no, please apply for assistance at the DHHR and the hospital.

Be able to substantiate need – ***if you have been out of work due to illness or injury; ATTACH copies of medical bill paid.***

HAVE YOU APPLIED FOR ASSISTANCE BEFORE? _____YES _____NO

I acknowledge that I have read and understand the attached ***General Eligibility Requirements and Regulations*** and that my application complies with them. Under penalties of perjury, I attest that all the information provided by me in this application is **TRUE AND CORRECT** and that providing incorrect information is cause for assistance denial.

____

Applicant's signature Date

EMPLOYOR CERTIFICATION

I, ______________________________ HEREBY CERTIFY THAT ____________________

____________________________ HAS WORKED FOR ME AS A ____________________

SINCE____________ WEEKLY PAY OF $______________ DAILY PAY OF $____________

I CERTIFY UNDER PENALTY OF PERJURY THAT THE ABOVE PERSON WORKS FOR ME AT THE WAGES INDICATED.

____ ________________

EMPLOYER'S SIGNATURE DATE PHONE

==

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EMPLOYER'S SIGNATURE DATE PHONE

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COMMITTEE

APPROVED FOR: _____

_____; **DATE**_____

DENIED FOR: _____

_____; **DATE**_____

TABLED FOR: _____

_____; **DATE**_____

YES____ **NO**____ _____ **YES**____ **NO**____ _____

YES____ **NO**____ _____ **YES**____ **NO**____ _____

YES____ **NO**____ _____ **YES**____ **NO**____ _____

YES____ **NO**____ _____ **YES**____ **NO**____ _____

NOTES: