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CLIENT ASSISTANCE PROGRAM ELIGIBILITY FORM

Eligibility for this program is based on financial need.

Proof of income is required to qualify for the Client Assistance Program (CAP). The information must be updated every three (3) months and any time your income, household size and/or medical insurance status changes. If you are unable to provide the required information on the day of your visit but provide it to the clinic within fifteen (15) calendar days, the CAP discount will apply retroactively. If proof of income is not received within 15 calendar days, no discount will be applied. In either case, whether or not the discount has been applied to your fee(s), you are responsible for full payment of your bill.

Name _____ Date of Birth _____
 Last First Middle

Address: _____ Phone: _____

List your name and the name(s) of all individuals who live with you and contribute to or are supported by the household income:

Name	Relationship	Age	Sex	Employer	Income
	Self				

If you need more space, please continue on Attachment 1.

Do you currently have health insurance? Yes No

If yes, please provide the following insurance information:

Primary Insurance: _____
Address: _____ _____
Phone #: _____
ID #: _____
Group #: _____

Are you currently employed? Yes _____ No
Where

Do you work seasonally? Yes _____ No
Where

How much money do you bring in per month? \$ _____ Annually? \$ _____

Are you homeless? Yes No

If you are not working, how are you meeting your monthly expenses?

List all earnings that you are receiving in your household:

Yes	No	Category of Earnings	\$ Amount per month/year
		Wages, salary, and tips before deductions	
		Unemployment Compensation	
		Worker's Compensation Benefits	
		Social Security Benefits	
		Supplemental Security Income	
		Public Assistance/Alaska Temporary Assistance Program/ ATAP Cash Assistance	

	Veteran's Benefits	
	Military Subsidies (BAH, BAS, COLA)	
	Survivor Benefits	
	Pension or Retirement Income	
	Interest	
	Permanent Fund Dividend (PFD) from State of Alaska	
	Dividends (not including Alaska PFD)	
	Rents, Royalties, Estates and Trusts	
	Educational Assistance for general living expenses (Grants & Scholarships)	
	Alimony	
	Financial Assistance from Outside the Household (Foster Care, etc.)	
	Strike Benefits	
	Other Income	
	TOTAL	

Please list two references who are not living with you:

Name	Relationship	Address	Phone	Years Known

I authorize Hope Counseling Center to verify information provided on this application. I also authorize all government agencies, employers, financial institutions and any companies, agencies or persons listed herein to provide information about me to Hope Counseling Center. I understand that false statements made on this application are punishable. I certify that the statements regarding the persons and income in my household are true and correct to the best of my knowledge. I further understand if any information is found inaccurate, I may be denied a discount and/or subject to criminal prosecution for knowingly providing false information. I agree to notify Hope Counseling Center of all changes in income, address, living arrangements, number of household members and/or other circumstances. I understand that the information given above will be kept confidential, except for the purposes noted above, and not released without my written permission. I also understand that if I do not agree with any decision made concerning this application, I have the right for a review in writing.

Signature _____ Date _____

Printed Name _____

Declined: _____ Reason: [] Over Income [] Other____
Client Signature

STAFF USE ONLY

Verification of household size and income

Breakdown (carryover from pg. 2)

Household Size _____ Total Amount per Month \$ _____

Verified with: Pay Stub(s) Tax Form(s) Letter Other _____ Date: _____

Verified By _____ Effective Date _____

Expiration Date _____

Income:

- ≤ 100% FPL (Nominal Fee) 134 – 167% FPL (50%)
 101 – 133% FPL (25%) 168 – 200% FPL (75%)

-----**COMPLETE ONLY IF APPROPRIATE**-----

15 Calendar Day Grace Expires on: _____

Verification Needed: Pay Stub(s) Tax Form(s) Letter Other _____

I have been advised that I must provide proof of income to the center within fifteen (15) calendar days to receive the discount. I also have been advised that if I do not provide verification of my income by the above date, I will be required to pay 100% of the fee.

Client Signature

Witness Signature

