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Phone (907) 451-8208 • Fax (907) 451-8207
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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		Fem		
			Fem		
			Fem		
			Fem		

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

ATTACHMENT 1

Name	Relationship	Age	Sex	Employer	Income
			Fema		
			Fema		
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SUBMIT FORM