

**Hope Counseling and Consulting LLC**  
 926 Aspen St • P.O. Box 73536 • Fairbanks, Alaska 99707  
 Phone (907) 451-8208 • Fax (907) 451-8207

**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). Along with this application, you will need to submit a **statement of earned income**, which may be obtained from the Federal Building on 12<sup>th</sup> Street. As an alternative, you may submit your most recent **income tax return**, or your **two most recent pay stubs**. The information must be updated every six months and anytime your income, household size and/or medical insurance status changes. Whether or not a 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: _____<br>_____  |
| 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 and benefits 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   |  |
|  | <b>TOTAL</b>   |  |

**Please list two references who are not living with you:**

| Name | Relationship | Address | Phone | Years Known |
|------|--------------|---------|-------|-------------|
|      |              |         |       |             |
|      |              |         |       |             |

I authorize Hope Counseling and Consulting 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 and Consulting. 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 and Consulting 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 |
|------|--------------|-----|-----|----------|--------|
|      |              |     |     |          |        |
|      |              |     |     |          |        |
|      |              |     |     |          |        |
|      |              |     |     |          |        |
|      |              |     |     |          |        |
|      |              |     |     |          |        |
|      |              |     |     |          |        |
|      |              |     |     |          |        |
|      |              |     |     |          |        |
|      |              |     |     |          |        |
|      |              |     |     |          |        |
|      |              |     |     |          |        |
|      |              |     |     |          |        |
|      |              |     |     |          |        |
|      |              |     |     |          |        |
|      |              |     |     |          |        |
|      |              |     |     |          |        |
|      |              |     |     |          |        |
|      |              |     |     |          |        |
|      |              |     |     |          |        |