

**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: _____ _____
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?

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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

