CORNERSTONE HEALTH

Medical ▪ Counseling ▪ Recovery

2024 Sliding Fee Discount Application

Last Name	First Name	Primary Phone	Date Application Received
Mailing Address	City	State	Zip

Household Information

A household is defined as all members of a family, related or unrelated, who are living together & pooling financial resources, if the arrangements are considered permanent & support greater that room and board is provided.

Last Name	First Name	Relationship to applicant	DOB	Insurance
		Self		MCR- Medicare MCD – Medicaid P – Private N- none
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

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Please use this form as a guide. Bring this form back to the office when it is completed. Provide documentation of income for the past 30 days. If self-employed, please provide tax returns for the most recent year.

Income Source	Household Member Receiving Income	Monthly Gross Amount
Wages/Pay Stubs		
Retirement		
Unemployment		
Social Security		
Disability/SSI		
Alimony		
Child Support		
Foster Care		
AK Temp Assistance Program (ATAP)		
Worker's Comp		
Interest Income		
Rental Income		
Dividends (excluding PFD)		
Other Income		
	Total	$

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Please read the following statements, initial each one and sign below to show you agree.

_____ I authorize Cornerstone Health Counseling to verify information on my application.

_____ I understand that the information provided here will be kept confidential.

_____ I understand that I need to notify Cornerstone Health Counseling of any income changes that may affect my eligibility status.

_____ I certify that the statements made on the application regarding my household income, and all other items that pertain to eligibility are true and complete to the best of my knowledge.

_____ I understand that I will need to have my eligibility verified every six months.

Please provide the following information with your completed application:

1. Copy of most recent tax return.
2. Two most recent pay stubs.

_____ _____

Signature of Applicant or Authorized Representative Date

For Office Use Only

Verified By: _____ Date Application Received: _____

□ Approved Effective Date: _____ □ Denied

Comments: _____

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Annual Income

Family Size	Less than	25%		50%		75%	
1	$18,810	$18,811	$25,080	$25,081	$31,350	$31,351	$37,620
2	$25,540	$25,541	$34,053	$34,054	$42,567	$42,568	$51,080
3	$32,270	$32,271	$43,027	$43,028	$53,783	$53,784	$64,540
4	$39,000	$39,001	$52,000	$52,001	$65,000	$65,001	$78,000
5	$45,730	$45,731	$60,973	$60,974	$76,217	$76,218	$91,460
6	$54,460	$52,461	$69,947	$69,948	$87,433	$87,434	$104,920
Sliding Fee	0%	25%		50%		75%	

Monthly Income

Family Size	Less than	25%		50%		75%	
1	$1,568	$1,569	$2,090	$2,091	$2,613	$2,614	$3,135
2	$2,128	$2,129	$2,838	$2,839	$3,547	$3,548	$4,257
3	$2,689	$2,690	$3,586	$3,587	$4,482	$4,483	$5,378
4	$3,250	$3,251	$4,333	$4,334	$5,417	$5,418	$6,500
5	$3,811	$3,812	$5,081	$5,082	$6,351	$76,218	$7,622
6	$4,372	$4,323	$5,829	$5,830	$7,286	$87,434	$8,743
Sliding Fee	0%	25%		50%		75%	

This sliding fee scale is based on the 2024 Alaska Poverty Income Guidelines per Federal Register and Notices