



Sliding Fee Discount Application

Client Information

First Name: _____ M.I.: _____ Last Name: _____

Mailing Address: _____ State: _____ City: _____ Zip Code: _____

Primary Phone: _____

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 than room and board is provided.

Household Member	Relationship to Applicant	Insurance (Medicare, Medicaid, Private, None)
Applicant	Self	
2.		
3.		
4.		
5.		
6.		
7.		
8.		

Please provide one of the following to the Cornerstone Health Counseling office staff with your completed application:

- 1. Most recent tax return**
- 2. Two most recent paystubs**
- 3. Two months of bank statements**

(907) 522-7080

2121 Abbott Rd, Anchorage, AK 99507

cornerstonehealthalaska.org

C a r e f o r t h e w h o l e p e r s o n



Please use this form as a guide. Return this form to the counseling office when it is completed. Provide documentation of income for the past 3 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 Temporary Assistance (ATAP)		
Worker's Comp		
Interest Income		
Rental Income		
Dividends (excluding PFD)		
Other Income		
		TOTAL: \$

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

___ I authorize Cornerstone Health Counseling to verify the 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.

Signature of Applicant or Authorized Representative

Date



Office Use Only

Financial Verification Received (Tax return, pay stubs, bank statements)

Date Application Received: _____ Verified By: _____

Approved Denied

If Approved: 100% 75% 50% 25%

Effective Dates: __/__/__ to __/__/__