FRONT STREET CLINIC

DISCOUNT ELIGIBILITY APPLICATION

(ALL INFORMATION IS CONFIDENTIAL)

Definitions:

Household members:

For the purpose of determining qualification for discounted services a HOUSEHOLD IS 1) all persons living in a single dwelling unit, related or unrelated 2) who pool financial resources in addition to room and board and 3) hold themselves out to the community as a family.

Income:

Income is defined as cash receipts received from all sources before taxes, including:

- Wages and Salaries, (Tax documents:W-2, Federal Tax Return, 1099, Pay stubs or statement from employer)
- Receipts from self-employment less operating expenses, (Tax Documents/IRS form 1040 schedule SE)
- Payments from public assistance, social security, strike benefits, military allotments, disability, child support, government or private pensions, regular insurance or annuity payments (Documents, Check Stubs)
- Income from dividends, interest, rents, royalties, estates or trusts (Copies of Documents or Tax Documents)

Alaska Permanent Fund Dividends *are not* counted as income.
State adoption subsidies *are not* counted as income.

Eligibility Determination
PROOF OF INCOME MUST ACCOMPANY THIS APPLICATION

☐ Based on the income guidelines provided, I am overqualified for discounted services.

Household members/ Household income

List your name(s) of **ALL** household members as well as birthdates. If an individual had a name change in the last year, please include the previous name in parentheses next to that individual.

Household Member		Birthdate	Household Income **(Complete one Column)**	
	First and last name (legal name)		Annual **OR**	Monthly
Self:				
Spouse:				
Other:				
Other:				
Other:				
Other:				
Other:				
Total				

This information must be updated annually, and anytime your income or household size changes.
I understand that the information I provide on this form is subject to verification. I certify that the above information is true and correct to the best of my knowledge.

_____ _____
Name and mailing address of person completing form (Print) Signature / Date

_____ _____
FSC/SEARHC Representative Signature % of discount applied / Date

Office Use Only:
Patient Notified By: ☐ Verbal ☐ Mail Date:_____ Initials:_____ IHS Eligible ☐ Y ☐ N
Homeless ☐ Y ☐ N