



## 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 LEGAL name and the LEGAL 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 First and last name (legal name)	Birthdate	Household Income (Complete one Column)	
			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
AICS/SEARHC Representative Signature	% of discount applied / Date

Office Use Only: Patient Notified By: <input type="checkbox"/> Verbal <input type="checkbox"/> Mail    Date: _____    Initials: _____ <div style="float: right;">           IHS Eligible <input type="checkbox"/> Y <input type="checkbox"/> N            Homeless <input type="checkbox"/> Y <input type="checkbox"/> N         </div>
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