

- Pick-Up
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- Courier



## Medications for Hope Eligibility Attestation Form

**Applicant Name:** \_\_\_\_\_ **Birth Date:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Medical Record Number:** \_\_\_\_\_

**Part 1. Participant Income Information**

- I hereby attest that my current estimated annual income from wages is: \$ \_\_\_\_\_
- Additional income sources such as social security disability income, workers compensation benefits, dividends, interest, assistance from family, friends or charity, public assistance and/or food stamps, or other sources: \$ \_\_\_\_\_
- Those other sources of income are: \_\_\_\_\_
- Income for all others living in my household during the same 12-month period: \$ \_\_\_\_\_
- Number of individuals in household: \_\_\_\_\_
- **Total income from wages and all other sources:** \$ \_\_\_\_\_

**Part 2. Insurance Information:** I hereby attest that I am not covered by any form of prescription insurance, nor am I covered by any form of government-sponsored health insurance, including Medicare, Medicaid, VA benefits, or other coverage.

**Part 3. Signature (Required):** I certify that all of the above information is true and accurate. I understand that this information is to be used to determine eligibility for the Dispensary of Hope and its related access sites. I will notify staff of any changes in employment, income or insurance prior to having additional prescriptions filled.

**Applicant Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Staff Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**FOR PHARMACY USE ONLY:** Please compare the total income in Part 1 above with the 2023 Federal Poverty Guidelines Table below. Applicants must be at or below 300% of Federal Poverty Guidelines and either lack insurance or are covered under a plan with no prescription coverage. Patients with Medicaid, Medicare, VA benefits, or other coverage are not eligible for Dispensary of Hope medication.

**2023 Poverty Guidelines for the 48 Contiguous States and the District of Columbia Effective 1/24/2023**

Persons in family/household	Poverty Guideline	300% FPL
1	\$14,580	\$43,774
2	\$19,720	\$59,160
3	\$24,860	\$74,580
4	\$30,000	\$90,000
5	\$35,140	\$105,420
6	\$40,280	\$120,840
7	\$45,420	\$136,260
8	\$50,560	\$151,680

For families/households with more than 8 persons, add \$5,140 for each additional person.