Eligibility Attestation
PHARMACY USE ONLY

APPLICANT NAME ____ **DOB:** _______________

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, including Medicare, Medicaid or VA 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:** __________________

Attention Staff: *Please compare the Total income in Part 1 above with the 2016 Federal Poverty Guidelines Table below. Applicant must be at or below 200% of Federal Poverty Guidelines and either lack insurance or are covered under a plan with no prescription coverage. Patients with Medicaid, Medicare, or VA coverage are not eligible for Dispensary of Hope medication.*

2016 Poverty Guidelines for the 48 Contiguous States

Persons in family/household	Poverty guideline	200% FPG
1	$11,880	$23,760
2	$16,020	$32,040
3	$20,160	$40,320
4	$24,300	$48,600
5	$28,440	$56,880
6	$32,580	$65,160
7	$36,730	$73,460
8	$40,890	$81,780
For families/households with more than 8 persons, add $4,160 for each additional person.		