

Qualification Questionnaire

Patient Information

Name _____ DOB _____

Does the patient have any income documentation with them or accessible to them online?

_____ YES _____ NO

If YES, please explain what types of documentation:

Income Information

- **Please request an estimate:** Patient's current estimated annual household income from wages (*Included: 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*):

Total: \$ _____

- I certify that I have attempted to gain as much income information from this patient as possible.

_____ YES

Insurance Information

I certify that I have attempted to gain insurance status from the patient.

_____ YES

Signature (Required)

I certify that all of the above information is true and accurate to the best of my knowledge and that I have attempted to gain proper income and insurance information.

Based on the information I have gathered from the patient, I believe this patient is eligible for a first fill of Dispensary of Hope medication.

_____ YES _____ NO

Applicant Signature _____ Date: _____

Staff Signature: _____ Date: _____

I certify that I have asked the patient to bring the following documentation on their next visit to the clinic:

Poverty Guidelines

Please compare the Total Income in the Qualification Questionnaire with the 2020 Federal Poverty Guidelines Table below. Applicant must be at or below 200% of the Federal Poverty Guidelines and either lack insurance or be covered under a commercial plan with no prescription coverage. Patients with Medicaid, Medicare, or VA coverage are not eligible for Dispensary of Hope medication.

**2020 Poverty Guidelines for the 48 Contiguous States and the District of Columbia
Effective 1/15/2020**

Persons in family/household	Poverty guideline	200% FPG
1	\$12,760	\$25,520
2	\$17,240	\$34,480
3	\$21,720	\$43,440
4	\$26,200	\$52,400
5	\$30,680	\$61,360
6	\$35,160	\$70,320
7	\$39,640	\$79,280
8	\$44,120	\$88,240

For families/households with more than 8 persons, add \$4,480 for each additional person.

TEAR OFF THE SECTION BELOW & GIVE TO PATIENT

Continue receiving your medication free of charge!

ON YOUR NEXT VISIT, PLEASE BRING BY _____:
DATE

TAX RETURNS

FOOD STAMP ELIGIBILITY LETTER

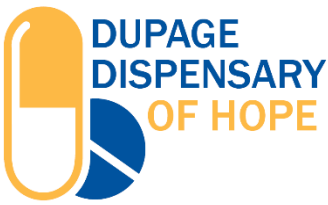
PAYCHECK STUBS

LETTER FROM EMPLOYER SHOWING
COMPENSATION

IRS FORM W2

LETTER OF SUPPORT

Comments: _____



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, 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 2020 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, VA benefits, or other coverage are not eligible for Dispensary of Hope medication.

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