DUPAGE DISPENSARY OF HOPE

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**
- ☐ **PAYCHECK STUBS**
- ☐ **IRS FORM W2**
- ☐ **FOOD STAMP ELIGIBILITY LETTER**
- ☐ **LETTER FROM EMPLOYER SHOWING COMPENSATION**
- ☐ **LETTER OF SUPPORT**

Comments: _____

_____

_____

DUPAGE DISPENSARY OF HOPE

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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