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: ____

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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:

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POVERTY GUIDELINES

Please compare the Total Income in the Qualification Questionnaire with the 2022 Federal Poverty Guidelines Table below. Applicant must be at or below 300% of Federal Poverty Guidelines and either lack insurance or are covered under a commercial plan with no prescription coverage. Patients with Medicaid, Medicare, or VA coverage are not eligible for Dispensary of Hope medication.

2022 Poverty Guidelines for the 48 Contiguous States and the District of Columbia
Effective 1/12/2022

Persons in family/household	Poverty Guideline	300% FPL
1	$13,590	$40,770
2	$18,310	$54,930
3	$23,030	$69,090
4	$27,750	$83,250
5	$32,470	$97,410
6	$37,190	$111,570
7	$41,910	$125,730
8	$46,630	$139,890
For families/households with more than 8 persons, add $4,720 for each additional person.		

TEAR OFF THE SECTION BELOW & GIVE TO PATIENT

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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: ____

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