NEIGHBOR'S PHARMACY

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, 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, with auditors, or pharmaceutical companies as required. 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 2024 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.*

2024 Poverty Guidelines for the 48 Contiguous States and the District of Columbia
Effective January 2024

Persons in family/household	Poverty Guideline	300% FPL
1	$15,060	$45,180
2	$20,440	$61,320
3	$25,820	$77,460
4	$31,200	$93,600
5	$36,580	$109,740
6	$41,960	$125,880
7	$47,340	$142,020
8	$52,720	$158,160
For families/households with more than 8 persons, add $5,380 for each additional person.		