DISPENSARY OF HOPE CHECKLIST AND INFORMATION FORM 2022

CHECKLIST-Please check yes or no

	Yes	No
I am a U.S. Resident (documented and undocumented)		
I DO NOT have prescription insurance		
❖ I am NOT covered by Medicare D/ Medicaid		
❖ I am NOT covered by TRICARE		
❖ I am NOT covered by the VA		
❖ I do NOT have Affordable Care Act Coverage		
My medical insurance does NOT have a prescription benefit plan		
My income is less than 300% Federal Poverty Limit ($40,700 for 1 person, $54,930 for 2 people, $69,090 for 3 people, $83,250 for 4 people)		

You are eligible to receive prescription medications through Dispensary of Hope if you answered YES to all prompts

Patient Profile Info-Please Print

Name: ____ **Date of Birth:** _______________

Gender (Male/Female/Other): _________________ **Preferred Phone:** _________________________

Home Address: ____

City: _______________________________________ **State:** _______________ **Zip Code:**_____________

Allergy Information:

Drug Allergies: Yes☐ No☐

If yes list all allergies:

Aspirin ☐ Penicillin☐ Tetracycline☐ Codeine☐ Morphine☐ Sulfa Drugs☐

Shellfish☐ Latex☐ ACE/ARBs☐ Other☐_________________________________

Reaction to drug allergy: ____

Please list all medication including over the counter and supplements you are currently on:

____

____

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:** ______________________

Please fax form to the specific Inspira Retail Pharmacy you would like to obtain your medications

Mullica Hill 856-221-4300 Vineland 856-221-4008

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