



**DISPENSARY OF HOPE PATIENT ENROLLMENT FORM 2026**

	Yes	No										
Are you a U.S. Resident? (either documented or undocumented)												
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.												
Is your income less than 300% of the Federal Poverty Limit (FPL)?												
<table border="1"> <thead> <tr> <th>Household Size</th> <th>300% FPL Examples</th> </tr> </thead> <tbody> <tr> <td>1 person</td> <td>\$47,880</td> </tr> <tr> <td>2 people</td> <td>\$64,920</td> </tr> <tr> <td>3 people</td> <td>\$81,960</td> </tr> <tr> <td>4 people</td> <td>\$99,000</td> </tr> </tbody> </table>	Household Size	300% FPL Examples	1 person	\$47,880	2 people	\$64,920	3 people	\$81,960	4 people	\$99,000		
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1 person	\$47,880											
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For Providers: I have verified this patient's medications are on the Dispensary of Hope formulary and in-stock at the selected Inspira pharmacy site		Please look at DOH formulary now										

**Patient Profile Information (Please Print)**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Gender (Male/Female/Other): \_\_\_\_\_ Preferred Phone Number: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

How did you hear about this program?  Provider  Pharmacist  Other: \_\_\_\_\_

**Allergy Information:**

- Drug Allergies?  Yes  No
- If Yes, please list all allergies:
  - Aspirin       Penicillin       Tetracycline       Codeine       Morphine       Sulfa Drugs
  - Shellfish       Latex       ACE/ARBs       Other: \_\_\_\_\_
- Please list reaction that occurs with each drug allergy listed: \_\_\_\_\_

Please list all medications you currently take, including over the counter medications and supplements:

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I certify that all 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 this completed form to the specific Inspira Retail Pharmacy you would like to obtain your medications from: Mullica Hill 856-221-4300 or Vineland 856-221-4008