DISPENSARY OF HOPE

SELF-ATTESTATION OF INCOME

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 health insurance, including Medicare, Medicaid or any private insurance.

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:** _____

Attention Staff: *Please compare the Total income in Part 1 above with the 2014 Federal Poverty Level Table below. Applicant must be at or below 200% of the Federal Poverty Level* ***and*** *uninsured to be eligible for Dispensary of Hope medications.*

Household Size	200%
1	$23,340
2	$31,460
3	$39,580
4	$47,700
For each additional person, add	$8,120