DISPENSARY OF HOPE CHECKLIST AND INFORMATION FORM 2024

	Yes	No
Are you a U.S. Resident? (either documented or undocumented)		
Do you have any of the following prescription insurances? • **Medicare Part D** • **Medicaid** • **TRICARE** • **Coverage through the U.S. Department of Veterans Affairs (VA)** • **Affordable Care Act Coverage**		
If you do have insurance, does your medical insurance have a prescription benefit plan?		
Is your income less than 300% of the Federal Poverty Limit (FPL)?		

Household Size	300% FPL Examples
1 person	$45,180
2 people	$61,320
3 people	$77,460

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:

_____

_____

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 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