PATTERSON-MCCALLUM-MARETA
CHARITABLE PHARMACY

Eligibility Attestation

Applicant Name: _____DOB: _____

Address: _____ City: _____ State: _____

Number of individuals living in household: _____

Part 1: Participant Income Information*

I hereby attest that my current estimated annual income from wages is: $ _____

Other than wages, check all sources of additional income this year:

☐ Social security disability income: $_____ ☐ Interest: $_____

☐ Workers compensation benefits: $_____ ☐ Dividends: $ _____

☐ Assistance from family, friends or charity: $_____

☐ Public assistance and/or food stamps: $_____

☐ Other sources: $_____

Income for all others living in my household during the same 12-month period:
$ _____

Total income from wages and all other sources listed above: $ _____

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 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: _____

*The total income in Part 1 above will be compared to the current year's Federal Poverty Guidelines to determine eligibility. Applicants must be at or below 300% of Federal Poverty Guidelines and either lack insurance or be 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.

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2026 Poverty Guidelines for the 48 Contiguous States and the District of Columbia Effective January 2026		
Persons in family/household	**Poverty Guideline**	**300% FPL**
1	$15,650	$47,880
2	$21,150	$64,920
3	$26,650	$81,960
4	$32,150	$99,000
5	$37,650	$116,040
6	$43,150	$133.080
7	$48,650	$150,120
8	$54,150	$167,160
For families/households with more than 8 persons, add $5,500 for each additional person.		

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