

340B Pharmaceutical Discount Policy

FOR OFFICE USE ONLY	
Name	
Annual Income	
# In Household	
Date Given	
Application is due within 15 days from the above date	
Allow 7 business days	

Discount Policy

Discounts are offered based upon household income and size according to the Federal Poverty Guidelines. A sliding fee schedule is used to calculate the basic discount and is updated each year using these guidelines. Once approved, the **discount will be honored for 12 months, after which the patient must reapply.**

Discount Application Process

A completed application including required documentation of the **home address, HOUSEHOLD income (every member in the household with income), and insurance coverage must be on file and approved by Willow Valley before a Pharmaceutical discount card will be granted.**

If any of the above information is not provided with your application it will be returned to you until all required information is received.

Willow Valley Medical Clinic

340B Pharmaceutical Discount Application

Discounted/Sliding Fee Application

The 340B program is federally directed with the intent to stretch resources as far as possible. Discounts are offered based upon family income and size. The discount will only apply to medications from Larry's Family Pharmacy or Preston Drug, and not to any other pharmacy. Please complete the following information and return to the front desk to determine if you or members of your family are eligible for the 340B program.

This form must be completed every 12 months to continue eligibility. Please inquire at the front desk if you have any questions.

Number of related persons living in your household:

Family Assistance Plan Application

Name of Head of Household (Home owner)	Social Security Number			
Home Address	City	State	Zip	Phone
Health Insurance Plan	Place of Employment			

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List the people in your household **under 18-years-old below**. (Any persons over 18 must fill out their own application.) Please list the total monthly income for each person in the home. Include any monthly income **including paychecks, profits, interest, savings, welfare, unemployment, child support, gifts, grants, etc.** Attach another sheet if you need to provide more information than space allows.

NAME	DOB	INCOME	INSURANCE
Self			Company: ID#
Spouse			Company: ID#
Dependent			Company: ID#
Dependent			Company: ID#
Dependent			Company: ID#
Dependent			Company: ID#
Dependent			Company: ID#

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Annual Household Income

Provide proof of income for each member with income in the household including **last 3 paystubs** or **most recent taxes, unemployment, child support, grants, etc.** (See checkbox below)

Source	Self	Spouse	Other	Total
Gross wages, salaries, tips, etc.				
Social security, pension, annuity, and veteran's benefits				
Alimony, child support, military family allotments				
Income from business self-employment, and dependents				
Rent, interest, dividend, and other income				

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I certify that the family size and income information shown above is correct. Copies of tax returns, pay stubs, and other information verifying income is required before a discount is approved.

Name (Print) Date

Signature

Verification Checklist (attach copies)	Yes	No
Identification/Address: Driver's License, birth certificate, employment ID, social security or other	<input type="checkbox"/>	<input type="checkbox"/>
Income: Prior year tax return, 3 most recent pay stubs, or other	<input type="checkbox"/>	<input type="checkbox"/>
Insurance: Insurance card(s)	<input type="checkbox"/>	<input type="checkbox"/>

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340B SLIDING FEE SCHEDULE

INCOME VERIFICATION IS REQUIRED

Poverty Level*	0%-150%		151%-200%	
Family Size				
1	\$0	\$18,735	\$18,736	\$24,980
2	\$0	\$25,365	\$25,366	\$33,820
3	\$0	\$31,995	\$31,996	\$42,660
4	\$0	\$38,625	\$38,626	\$51,500
5	\$0	\$45,255	\$45,256	\$60,340
6	\$0	\$51,855	\$51,856	\$69,180
7	\$0	\$58,515	\$58,516	\$78,020
8	\$0	\$65,145	\$65,146	\$86,860
For each additional person, add		\$6,630		\$8,840