
340B PRESCRIPTION DISCOUNT PROGRAM

As a federally qualified community health center, the Harrisonburg Community Health Center (HCHC) participates in the 340B Prescription Discount Program. This program gives uninsured and low-income patients of the Harrisonburg Community Health Center access to reduced prices on prescriptions. In order to provide this program, the Harrisonburg Community Health Center partners with WilliamsonHughes Pharmacy. Being conveniently located next to the HCHC, our Health Center patients will find WilliamsonHughes Pharmacy to have a helpful and very knowledgeable staff.

What should you know about the 340B Prescription Program?

- 340B discount prices are **ONLY** available at WilliamsonHughes Pharmacy.
- Prescriptions **must** be written by HCHC providers.
- You will usually **save 20% to 50%** on your prescriptions.
- The cost of your prescriptions **may not** always be the same, but you will pay the **lowest** price available.

Find WilliamsonHughes Pharmacy right next door at:

WilliamsonHughes Pharmacy
563 Neff Avenue
Harrisonburg, VA 22801-3492
(540) 434-2372
www.williamsonhughespharmacy.com

Hours:

Monday – Friday: 9:00 am – 6:00 pm

Saturday: 9:00 am – 1:00 pm

Sunday: CLOSED

SLIDING FEE DISCOUNT APPLICATION

Is anyone in your household already on the sliding scale? If so, please provide their names.

Applicant's Full name:	Social Security Number:
Address:	Date of Birth (DOB):
City, State, Zip	Patient Number:
Primary Phone number:	Other Phone:

HOUSEHOLD INFORMATION MUST BE COMPLETED FOR ALL APPLICANTS

List all members of household and date of birth

Applicant's Full name:	Date of Birth (DOB):
Full name:	Date of Birth (DOB):
Full name:	Date of Birth (DOB):
Full name:	Date of Birth (DOB):
Full name:	Date of Birth (DOB):

HOUSEHOLD INCOME (Proof of Income must be copied and attached)

Household income is defined as all income coming in to the home including but not limited to wages earned through employment, government assistance (social security, food stamps, etc.), disability (short or long term), and unemployment benefits. You must provide proof of one month's worth of income from all sources. You may use the previous years 1040 tax form if that more accurately reflects your household income.

CHECK ALL sources of income:

- | | |
|--|--|
| <input type="checkbox"/> Self-Employment Wages | <input type="checkbox"/> Child Support |
| <input type="checkbox"/> Tips | <input type="checkbox"/> Public Assistance |
| <input type="checkbox"/> Unemployment Benefits | <input type="checkbox"/> Housing Allowance |
| <input type="checkbox"/> Social Security | <input type="checkbox"/> Military Family Allotment |
| <input type="checkbox"/> Pension Benefits | <input type="checkbox"/> VA Benefits |
| <input type="checkbox"/> Trust Fund Disbursement | <input type="checkbox"/> Training Stipends |
| <input type="checkbox"/> Scholarships | <input type="checkbox"/> Grants |
| <input type="checkbox"/> Food Stamps and any other forms of financial support. | |

SLIDING FEE DISCOUNT APPLICATION (continued)

IF YOU ARE UNEMPLOYED

If unemployed and you receive no income, does someone from outside of the household provide support for you: YES NO

If YES, that person or persons needs to complete a Letter of Support which can be provided to you by the eligibility coordinator.

Has the applicant been screened for Medicaid, FAMIS, or other assistance by the Department of Social Services?

YES NO If yes, why does the patient not receive the above aid?

AFFIDAVIT: By signing, I attest that as of the date of my signature, the income sources listed are all of my household income, the household members listed are all solely dependent on that income, and the explanation provided to verify my income level is true. **I understand that if the information provided is found to be incomplete or fraudulent I will be removed from the sliding scale permanently.**

APPLICANT/RESPONSIBLE PARTY SIGNATURE

Patients Do Not Complete the Information Below

VALID UNTIL: _____ Office Staff Signature: _____

Review Date: _____ Eligibility Coordinator Signature: _____