



Stephens Pharmacy

1100 S. Springfield Avenue, Bolivar, MO 65613
citizensmemorial.com

Dear Patient,

Citizens Memorial Hospital knows patients are concerned about the high cost of prescription medications. As a participant in the federal 340B Drug Pricing Program, CMH receives discounts on drugs purchased for use by CMH outpatients. We have attempted to pass along a significant portion of these discounts to our patients.

As with virtually all programs operated by the federal government, the 340B program includes numerous requirements for participating hospitals. In an effort to ensure compliance with these government requirements while continuing to offer drug discounts to our patients, we have developed criteria to help determine patients eligible for drug discounts.

Enclosed is an application for use by patients interested in receiving drug discounts on prescriptions written by eligible CMH providers. Patients who have completed this application and meet financial criteria related to income, assets and/or out-of-pocket drug expenditures will be eligible for such discounts.

Program renewal is required annually. During the renewal process, patients are asked to provide the following documents:

- Completed application
- Last tax return and/or Social Security benefits statement
- Last 2 months' bank statements
- 12 months' out-of-pocket pharmacy expense report
- Last month's paystubs

Completed applications can be dropped off at any CMH Clinic or Pharmacy or mailed to the address below. Applications are reviewed within three business days. You will receive a call from the Medication Access Specialist once your application has been processed. Applicants approved for program participation will receive a member card in the mail. Participating 340B Pharmacies are identified within the approval packet.

Please contact the Medication Access Specialist if you have any questions about the application or program benefits. We look forward to continuing to serve your health care needs.

Sincerely,
CMH Medication Access Specialist
Citizens Memorial Hospital
1500 North Oakland Avenue
Bolivar, MO 65613
417-328-6108

Citizens Memorial Hospital District | Citizens Memorial Health Care Foundation

An equal opportunity employer M/F/D/V | Affirmative Action | Services provided on a non-discriminatory basis



Drug Discount Program Application

(Last updated 1/1/24)

Patient Name (Last,First,MI)		Date of Application
Social Security #	Date of Birth	Phone #
Street Address		City
State	Zip	Yearly gross Income \$
Do you have Medicaid <input type="radio"/> Yes <input type="radio"/> No		Name of Insurance:
Insurance Premiums \$		Monthly <input type="checkbox"/> Yearly <input type="checkbox"/>
Does your insurance have Pharmacy coverage?		Yes <input type="checkbox"/> No <input type="checkbox"/>
Total household Out of Pocket Drug Expense (including dependants) \$		Monthly <input type="checkbox"/> Yearly <input type="checkbox"/>

Household Assets:

Banking Accounts (Checking, Savings & Cds) \$	\$
Investments (IRA, Stocks, Bonds)	\$ -
Realestate Investments less Debt on Realestate (Include Primary Residence & Acreage)	\$ -

Total Household Assets \$ -

Sources of Income (household)	Amount	Weekly	Frequency Monthly	Yearly
Salary/Wages before Deductions	-	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Public Assistance	-	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social Security Benefits	-	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Retirement Income	-	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alimony/Child Support	-	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unemployment	-	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Workmen's Compensation	-	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rental Income	-	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Monetary Support	-	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Total Yearly

Household Members		
Name	Date of Birth	Relationship

For office use only: Approved ☐ Yes ☐ No Initials: _____

***The following documents will need to be submitted after October 1st of this year to renew your application for next year.
-last tax return, last 2 bank statements, last month's paystubs, 12 months out of pocket expense report from pharmacy.