To Be Completed by Out of State Pharmacy Applicants

1. Are you enrolled in Medicaid in your home state or in any other state? If yes, provide documentation of your enrollment(s), such as a letter from the state you are enrolled in.

   ☐ Yes ☐ No

2. What services do you intend to provide to New York State Medicaid recipients? Please be specific, listing the top ten medications that you expect will be dispensed and all other services you will be providing. If necessary, please use a separate sheet of paper.

   1. _____ 6. _____
   2. _____ 7. _____
   3. _____ 8. _____
   4. _____ 9. _____
   5. _____ 10. _____

   Other services: _____
   _____

3. How will you provide services to New York State recipients? (i.e. Walk-in service, mail order, home delivery, services to facility) _____
   _____
   _____

4. If any services will be provided as mail order or delivery, including Federal Express or UPS, the following questions must be answered.

   a. How will you receive a prescription?
   _____
   _____

   b. How will the items be delivered and how long will delivery take?
   _____
   _____

   c. How will you ensure delivery to the recipient?
   _____
   _____

   d. How will you handle a complaint, including non-receipt of medication by the recipient or the receipt of the wrong medication?
   _____
   _____

   e. How will you handle counseling and education pertaining to the medications dispensed?
   _____
   _____

5. Where do the New York State recipients that you plan on providing services for reside (New York State or state in which you are located)?

_____
_____

6. Do you have any contracts with any homecare agencies, adult homes, nursing homes, or any other facilities where you would deliver medications? Please list, including the facility or agency name, address and phone number. (Use separate sheet of paper, if necessary.)

7. If you do not have a contract with any of the above, but provide services on behalf of a New York State Medicaid recipient affiliated or residing in any of the above, please list. (Use separate sheet of paper, if necessary.)

8. Are you located near a major hospital or medical facility that services New York State recipients? If yes, provide the name of the facility.

_____
_____

9. a. What is your total annual revenue?

_____

b. Of your total revenue, what percentage is conducted as mail order/delivery?

_____

c. What is the estimated percentage of your total annual revenue that you will derive from New York State Medicaid?

_____%

d. Of the estimated dollar value billed to New York State Medicaid, what percentage will be mail order? _____

e. Of the estimated dollar value billed to New York State Medicaid, what percentage will be from services to recipients in nursing homes, adult homes or any other agencies or facilities noted in Questions 6 or 7 above?

_____

Signature _____ Date _____