

d. Provide the name and address to whom the rent is paid.

e. If rent is paid to a corporation or partnership, list the names of the officers, directors, principal stockholders, partners and any NYS Medicaid Program provider numbers, National Provider Identifiers or professional licenses held.

<u>Last Name, First Name</u>	<u>Medicaid Number/NPI/ Professional License</u>
_____	_____
_____	_____

3. If the business location was previously a place at which NYS Medicaid pharmacy services were rendered, list the NYS Medicaid Provider Number/National Provider Identifier(s) of the prior owner(s).

4. Enclose copies of any promissory notes, sales agreements and any other relevant documents pertaining to the sale.

5. Estimate the dollar value of the pharmaceutical stock and medical supplies currently on hand. Please attach a detailed list of your current inventory. (If there has recently been an ownership change, submit all supplier invoices or inventories from previous owners that verify stock on hand.)

6. Estimate the percentage of business that will be billed to the NYS Medicaid Program. _____ %

7. a. Identify the name, address and account number(s) of the bank(s) to be used by the business.

<u>Name of Bank</u>	<u>Address</u>	<u>Account Number</u>
_____	_____	_____
_____	_____	_____

b. Provide the names of all personnel authorized to sign corporate checks against those accounts.

<u>Person(s) Authorized to Sign Checks</u>

8. Attach a statement identifying the persons who will be authorized to sign NYS Medicaid Program claims and provide original examples of their signatures. **Signature stamps, photocopies, etc., are not acceptable.**

9. List the name and license number of each pharmacist. State the days and hours of the week the pharmacist will be working.

<u>Name</u>	<u>License Number</u>	<u>Days of the Week Worked</u>	<u>Hours of the Week Worked</u>

10. Indicate the days and corresponding hours the pharmacy will be open.

Monday	_____ to _____	Friday	_____ to _____
Tuesday	_____ to _____	Saturday	_____ to _____
Wednesday	_____ to _____	Sunday	_____ to _____
Thursday	_____ to _____		

11. Indicate which services your pharmacy provides and how they are provided.

- | | | |
|--|----|-------|
| a. Free delivery. Please specify any limitations. | a. | _____ |
| b. Emergency service: | b. | _____ |
| After hours phone number | | _____ |
| After hours beeper number | | _____ |
| c. Health counseling (e.g. blood pressure checks, diabetic care, etc.) Please be specific. | c. | _____ |
| | | _____ |
| | | _____ |
| d. Multilingual counseling. Please identify the language(s) spoken and indicate which pharmacist or supervising pharmacist speaks the language(s) listed. | d. | _____ |
| | | _____ |
| | | _____ |
| e. Multilingual labeling. Please specify the language(s). | e. | _____ |
| | | _____ |
| f. Compound prescriptions. | f. | _____ |
| g. Private consultation area. Please describe. | g. | _____ |
| h. Patient information leaflets. (Please attach a copy). | h. | _____ |
| i. Drug and allergy monitoring. Please explain. | i. | _____ |
| | | _____ |
| j. How does your establishment provide access to the handicapped (ramps, passage, parking, etc.)? | j. | _____ |
| | | _____ |

Identify any additional circumstances or services which you offer that significantly improve health services to your clients other than those listed above.

12. Explain how your customers are made aware of the services your pharmacy provides.
- _____
- _____
- _____
13. Of your total pharmacy revenue, what percentage is provided by mail order or delivery (i.e. Fed Ex, UPS, US Mail, etc.)?
- _____
- a. Identify the types of medication or supplies that you provide by mail order or delivery.
- _____
- _____
- b. How do you provide these services to your customers?
- _____
- _____
- c. Where do the customers that receive these services reside?
- _____
14. Provide the name and telephone number of the accountant for the business.
- _____
- _____
- _____
15. Provide the name, address and telephone number of the attorney for the business.
- _____
- _____
- _____
16. a. Are you an out of state provider of pharmacy services interested in participating in the NYS Medicaid Program? Yes No
- b. Is this application for a single occasion for one NYS Medicaid Program recipient? Yes No
- c. If yes, please provide the first date of service for this recipient. / / / / /
M M D D Y Y

Owner's Name (Print): _____

Owner's Signature: _____ Date Signed: _____
(Signature Stamps Are Not Permitted)

Application Prepared by (Print): _____

Telephone Number: _____