Maryland
DEPARTMENT OF HEALTH

Office of Pharmacy Services
Small Rural Pharmacy Grants Program FY22
GRANT APPLICATION FORM

DIRECTIONS: Please complete and sign this application form and electronically submit it along with your pharmacy's current **IRS W-9 Form** via **email** to **Deanna Beebe** at deanna.beebe@maryland.gov by the submission deadline of **5:00 PM EST on Friday, October 15th, 2021**. *(If you are unable to submit your application via email, please contact* **Deanna Beebe** ***at least*** **48 hours** ***before the submission deadline*** *at* deanna.beebe@maryland.gov *or* **(410) 767-5701**.*)* **THANK YOU!**

*****IF YOU OWN MORE THAN ONE PHARMACY LOCATION FOR WHICH YOU WISH TO APPLY FOR GRANT FUNDING, YOU MUST SUBMIT A SEPARATE APPLICATION FOR EACH PHARMACY LOCATION.*****

DATE:	
SUBMITTER NAME:	
CONTACT NAME: (if different than SUBMITTER NAME)	
CONTACT EMAIL:	
CONTACT PHONE #:	
PHARMACY NAME:	
PHARMACY NPI:	
PHARMACY ADDRESS: (Street Address, City, State, Zip Code)	

TOTAL # OF STORE LOCATIONS UNDER SAME OWNERSHIP:	
TOTAL # OF MCO PRESCRIPTIONS FILLED BY THIS LOCATION IN CY2020: (Please see **Attachment 9** in the **RFA** for information on eligible prescriptions.)	
TOTAL # OF MCO PARTICIPANTS (PATIENTS) SERVED BY THIS LOCATION IN CY2020:	
TOTAL # OF ALL PRESCRIPTIONS FILLED AT THIS LOCATION IN CY2020:	
NAME(S) OF THE Maryland Medicaid HealthChoice MCOs THIS LOCATION HAD PRESCRIPTION CLAIMS WITH IN CY2020: (Please see **Attachment 9** in the **RFA** for the list of **the nine [9] Maryland Medicaid HealthChoice MCOs**.)	
IS PHARMACY CURRENTLY ENROLLED IN Maryland Medicaid:	☐ **Yes** ☐ **No**

Certification of Eligibility: *With this application, I certify that I am a small rural pharmacy located in Maryland and believe that I meet the eligibility requirements listed in the* ***SRPGP FY22 Request for Applications*** *and am interested in applying for this funding opportunity. If awarded funding, I will* ***only*** *use award funds for costs and fees directly related to dispensing prescriptions and that I will report the impact of this funding on the pharmacy's services for MCO participants to the Program via the* ***Final Report form*** *at the end of the grant funding period.*

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Signature of Authorized Representative ***Date***

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First and Last Name (Printed) ***Title***