



Office of Pharmacy Services
Small Rural Pharmacy Grants Program FY23
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 Wednesday, December 14th, 2022**. (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)	
SUBMITTER/CONTACT EMAIL:	
SUBMITTER/CONTACT PHONE #:	
PHARMACY NAME:	
PHARMACY NPI #:	
PHARMACY PHYSICAL ADDRESS: (Street Address, City, State, Zip Code)	
TOTAL # OF STORE LOCATIONS UNDER SAME OWNERSHIP:	
TOTAL # OF MCO PRESCRIPTIONS FILLED BY THIS LOCATION IN CY2021: (Please see Attachment 9 in the RFA for information on eligible prescriptions.)	
TOTAL # OF MCO PARTICIPANTS (PATIENTS) SERVED BY THIS LOCATION IN CY2021:	
TOTAL # OF ALL PRESCRIPTIONS FILLED AT THIS LOCATION IN CY2021:	
NAME(S) OF THE Maryland Medicaid HealthChoice MCOs THIS LOCATION HAD PRESCRIPTION CLAIMS WITH IN CY2021: (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 FY23 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.*

<i>Signature of Authorized Representative</i>	<i>Date</i>
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<i>First and Last Name (Printed)</i>	<i>Title</i>
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