Small Rural Pharmacy Grants Program

GRANT APPLICATION

PLEASE COMPLETE AND SIGN THIS FORM FOR YOUR APPLICATION SUBMISSION. THANK YOU.

******IF YOU HAVE MORE THAN ONE PHARMACY LOCATION ELIGIBLE FOR GRANT FUNDING, YOU MUST COMPLETE A SEPARATE GRANT APPLICATION FOR EACH ELIGIBLE 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 STORE OWNERSHIP:	
TOTAL # OF MCO PRESCRIPTIONS FILLED IN CY 2019 AT THIS LOCATION:	
TOTAL # OF MCO PARTICIPANTS SERVED IN CY 2019 AT THIS LOCATION:	
TOTAL # OF ALL PRESCRIPTIONS FILLED IN CY2019 AT THIS LOCATION:	
NAME(S) OF MCOs WHOSE PARTICIPANTS THE STORE SERVED IN CY2019:	
IS PHARMACY CURRENTLY ENROLLED IN MARYLAND MEDICAID?	☐ **Yes** ☐ **No**

***Certification of Eligibility**: With this application, I certify that I am a small pharmacy located in a rural area and am interested in applying for this funding opportunity. If awarded, we will use this funding for costs related to dispensing prescriptions, and report impact at the end of the grant period to the Program.*

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Signature of Authorized Representative *Date*

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First and Last Name (Printed) *Title*