

Please indicate your participation preferences:

<input checked="" type="checkbox"/> Hope Box Campaign	Free	<i>Communities recruit physicians to donate their excess sample medications. We provide a free Hope Box, free shipping and an itemized statement of donated medication.</i>
Instant Access Program		
<input type="checkbox"/> Donated Inventory	\$650/ month	<i>Tax-exempt clinics and pharmacies ("Access Sites") order from our on-line inventory of donated medications and dispense to uninsured patients--providing a 7-30-day first fill.</i>
<input type="checkbox"/> Discounted Inventory	Itemized pricing	<i>Access Sites purchase from our on-line inventory of discounted generic meds and diabetic supplies. Example: Box of 50 Strips for \$12.00, Meter for \$1.00</i>
<input type="checkbox"/> Continued Access Program	\$45/ patient	<i>Organizations enroll patients into manufacturers' patient assistant programs through our online, universal, application process. Patients receive 12 months of unlimited Rx coverage with patient navigation and refill support. Discount available with Instant Access Donated Inventory.</i>

Site Information

1. Name of Organization		2. Year of Founding	3. Telephone Number
4. Street Address	5. City, State, Zip	6. County	7. Fax Number
8. Days/Hours of Operation		9. Web Site	
10. Primary Contact Name/Title/Email/Phone		11. Secondary Contact Name/Title/Email/Phone	12. Invoice Recipient Name/Email
13. Tax Status <input type="checkbox"/> 501(c)(3) <input type="checkbox"/> 501(a)(1) <input type="checkbox"/> Other,		14. Income Percent Operating % vs. Non-operating %	

15. Please list services you provide:
16. Site Type (Check all that apply)

<input type="checkbox"/> Hospital	<input type="checkbox"/> Outpatient Pharmacy	<input type="checkbox"/> Primary Care Clinic	<input type="checkbox"/> FQHC
<input type="checkbox"/> Hospital Affiliated	<input type="checkbox"/> Retail Pharmacy	<input type="checkbox"/> Mental Health Clinic	<input type="checkbox"/> FQHC Look-Alike
<input type="checkbox"/> Critical Access Hospital	<input type="checkbox"/> Charitable Pharmacy	<input type="checkbox"/> Free Clinic	<input type="checkbox"/> Project Access/CJA
<input type="checkbox"/> Health Department	<input type="checkbox"/> Other, <i>please list:</i>		

Patient Information
17. If applicable, what guidelines do you use to qualify patients for free/reduced cost care through your facility? Please explain.

<input type="checkbox"/> Insurance Status (<i>i.e. uninsured</i>)	<i>Explain:</i>
<input type="checkbox"/> Income (<i>i.e. % of FPL</i>)	<i>Explain:</i>
<input type="checkbox"/> Residency (<i>i.e. county, city</i>)	<i>Explain:</i>
<input type="checkbox"/> Employment Status	<i>Explain:</i>
<input type="checkbox"/> Age	<i>Explain:</i>

18. What percent of your patients are uninsured? %	19. Do you require proof of income? <input type="checkbox"/> Yes <input type="checkbox"/> No	20. If yes, what documentation do you accept?
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21. Uninsured Patient Encounters/Visits

Daily #	Monthly #	Yearly #
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22. Uninsured Patient Fills (*Pharmacies only*)

Daily #	Monthly #	Yearly #
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Pharmaceutical Access

<p>23. Do you receive drug samples? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="padding-left: 20px;"><i>Donated by physicians</i> <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="padding-left: 20px;"><i>Received from reps</i> <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>25. Do you provide PAP assistance? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="padding-left: 20px;"><i>Patients per year</i> #</p> <p style="padding-left: 20px;"><i>Prescriptions per year</i> #</p> <p style="padding-left: 20px;"><i>Do you use PAP management software?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="padding-left: 20px;"><i>If yes, annual subscription cost?</i> \$</p> <p style="padding-left: 20px;"><i>Who coordinates PAP?</i> <input type="checkbox"/> Staff <input type="checkbox"/> Volunteer(s)</p>
<p>24. Do you purchase medicine? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="padding-left: 20px;"><i>Purchase with 340B pricing</i> <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="padding-left: 20px;"><i>Utilize a 340B contract pharmacy</i> <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="padding-left: 20px;"><i>Cover the cost of external fills</i> <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="padding-left: 20px;"><i>Estimated annual expenditures</i> \$</p>	

26. Are you interested in donating excess medications with at least 4 months of good dating? Yes No

27. Please indicate your top 5 needed medications for the following classes (include dose and annual quantity demand):

<p>Cardiology:</p> <p>1. _____</p> <p>2. _____</p> <p>3. _____</p> <p>4. _____</p> <p>5. _____</p>	<p>Endocrinology:</p> <p>1. _____</p> <p>2. _____</p> <p>3. _____</p> <p>4. _____</p> <p>5. _____</p>
<p>Gastroenterology:</p> <p>1. _____</p> <p>2. _____</p> <p>3. _____</p> <p>4. _____</p> <p>5. _____</p>	<p>Neurology/Mental Health:</p> <p>1. _____</p> <p>2. _____</p> <p>3. _____</p> <p>4. _____</p> <p>5. _____</p>
<p>Pulmonary:</p> <p>1. _____</p> <p>2. _____</p> <p>3. _____</p> <p>4. _____</p> <p>5. _____</p>	<p>Oncology:</p> <p>1. _____</p> <p>2. _____</p> <p>3. _____</p> <p>4. _____</p> <p>5. _____</p>
<p>Other:</p> <p>1. _____</p> <p>2. _____</p> <p>3. _____</p> <p>4. _____</p> <p>5. _____</p>	<p>Other:</p> <p>1. _____</p> <p>2. _____</p> <p>3. _____</p> <p>4. _____</p> <p>5. _____</p>

Please include the following attachments:

List of all staff prescribers and/or pharmacists. Include: *Name and State License, DEA, and NPI numbers* Copy of facility license

Dispensary of Hope Office Use Only

OIG Exclusion List Check	Initial _____	Date _____	
_____	_____	_____	_____
<i>Approval Signature 1</i>	<i>Date</i>	<i>Approval Signature 2</i>	<i>Date</i>