DISPENSARY OF HOPE
CONNECTING ABUNDANCE WITH NEED

Access Site Profile

Email to anita.stanford@dispensaryofhope.org or fax to 615-736-5624

☐ Clinic: $7,500 Annual Subscription Fee*   ☐ Pharmacy: $12,500 Annual Subscription Fee

General Access Site Information

Name of Participating Clinic or Pharmacy	Parent Organization			
Shipping Address	City	State	Zip Code	County

Main Telephone Number	Fax Number	Website Address

Tax Status ☐ 501(c)(3) ☐ Other, please explain:	Days/Hours of Operation

Facility Type *(Check all that apply)*

Clinic	Pharmacy	FQHC	Additional descriptions
☐ Charitable Clinic	☐ Charitable Pharmacy	☐ FQHC	☐ Hospital Affiliated
☐ Clinic w/ Pharmacy	☐ Outpatient Pharmacy	☐ FQHC with Pharmacy	☐ Health Department
☐ Rural Health Clinic	☐ Retail Pharmacy		☐ Student-run Clinic/Pharmacy
			☐ Other, please explain:

If clinic, please list services provided:	Licensed Pharmacy: ☐ Yes ☐ No Are you an open door pharmacy (serves the general public)? ☐ Yes ☐ No Mail Order Pharmacy: ☐ Yes ☐ No

Contact Information

Senior Leader Name	Title	Phone number & ext.	Email address
Primary Contact Placing DoH Orders	Title	Phone number & ext.	Email address
Secondary Contact Placing DoH Orders	Title	Phone number & ext.	Email address
DoH Invoice Recipient Name	Title	Phone number & ext.	Email address
Medical Director Name (Clinic)		Phone number & ext.	Email address

*Also applies to charitable clinics and FQHCs with a pharmacy license.

Patient Information

If applicable, what guidelines do you use to qualify patients for free/reduced cost care or prescriptions through your facility?

- ☐ **Insurance Status *(i.e. uninsured)*** *Explain:*
- ☐ **Income *(i.e. % of FPL)*** *Explain:*
- ☐ **Residency *(i.e. county, city)*** *Explain:*
- ☐ **Employment Status** *Explain:*
- ☐ **Age** *Explain:*

What percent of your patients are uninsured? %	Do you require proof of income? ☐Yes ☐ No	If yes, what income documentation do you accept?	Are you accepting new patients: ☐Yes ☐ No

Pharmaceutical Access

Does your facility purchase medicine?	☐Yes ☐No	**Does your facility receive drug samples?**	☐Yes ☐No
Purchase with 340B pricing	☐Yes ☐No	**Does your facility provide PAP assistance?**	☐Yes ☐No
Purchase without 340B pricing	☐Yes ☐No		
Utilize a 340B contract pharmacy	☐Yes ☐No		
Total estimated annual expenditures	$		

Does your facility have the capability to store DoH drugs in a temperature controlled, secured environment? ☐Yes ☐No

What system do you currently use to track medication dispensing?

- ☐ Electronic Medical Record Name:
- ☐ Pharmacy Operating System Name:
- ☐ We do not currently track medication dispensing
- ☐ Other, please explain:

Uninsured **Patient Encounters/Visits *(estimated)***			***Uninsured*** **30 Day Prescriptions *(estimated)***		
Daily #	Monthly #	Yearly #	Daily #	Monthly #	Yearly #

PLEASE INCLUDE THE FOLLOWING ATTACHMENTS:

*****CLINICS - Please list your medical director and include: Name, Title, State License Number, and Date of Birth; copy of clinic license if required by your state.**

*****CLINICS w/PHARMACY - Please list your medical director and pharmacist in charge and include: Name, Title, State License Number, and Date of Birth; copy of the pharmacy license and clinic license if required by your state.**

*****PHARMACIES - Please list the pharmacist in charge and include: Name, Title, State License Number, and Date of Birth; copy of pharmacy license.**

I hereby certify that the statements and information in this application form are true and correct to the best of my knowledge and belief.

Signature ____________________ *Date* ____________

Name ____________________ *Title* ____________________

Dispensary of Hope Office Use Only

OIG Exclusion List Check: *Initial* ________ *Date* ____________

Approval Signature 1 ____________ *Date* ________ *Approval Signature 2* ____________ *Date* ________