2006 APPLICATION FOR PARTICIPATION IN TEXAS TITLE XIX VENDOR DRUG PROGRAM

The organization listed below is hereby making application for participation in the Texas Title XIX Vendor Drug Program.

DATE: ________________________

NAME OF PHARMACY: ________________________

PHYSICAL ADDRESS: ________________________

PHARMACY TELEPHONE NUMBER: ______________________________ FAX NUMBER: ____________________

PHARMACY E-MAIL ADDRESS: ________________________

PAYMENT REGISTER MAILING ADDRESS: ________________________

CONTRACTS SHOULD BE MAILED TO: ________________________

(Individual or Business Name)

BUSINESS ADDRESS: ________________________

TEXAS PHARMACY LICENSE #: ________________________

STATE COMPTROLLER'S TAX ID #: ________________________

FEDERAL TAX ID #: ________________________

NEW PHARMACY (N) or a CHANGE OF OWNERSHIP (C): _________

OWNERSHIP INFORMATION : Complete the appropriate section regarding the ownership of the pharmacy.

GOVERNMENT AGENCY OR ENTITY:

Name of agency or entity: ________________________

You should enclose with this application a notarized statement indicating which individual has authority to sign the Vendor Drug contract. The statement must show the individual's position within the entity or agency.

SOLE PROPRIETORSHIP:

PROPRIETOR'S NAME: ________________________ SOCIAL SECURITY #: ________________________

TX DRIVERS LICENSE #: ____________________ EXPIRATION DATE: ________________ D.O.B.: _______________

PARTNERSHIP NAME: ________________________

General Partnership: ______ Limited Partnership: ______

If the partners are individuals, please list the following information for all partners. Indicate with a G all general partners. If additional space is needed, attach a separate page for the other partners. For partnerships with corporations or Limited Liability Companies as partners, see the corporation or LLC sections for additional required documents.

NAME: ________________________ SOCIAL SECURITY #: ________________________

TX DRIVERS LICENSE #: __________________________ EXPIRATION DATE: ____________ D.O.B.: _____________

NAME: ________________________ SOCIAL SECURITY #: ________________________

TX DRIVERS LICENSE #: __________________________ EXPIRATION DATE: ____________ D.O.B.: _____________

NAME: ________________________ SOCIAL SECURITY #: ________________________

TX DRIVERS LICENSE #: __________________________ EXPIRATION DATE: ____________ D.O.B.: _____________

For partnerships, enclose with this application:

1. A copy of the partnership agreement, or a written statement that no written partnership agreement exists.
2. A Chart of Organizational Structure showing all individuals or organizations holding ownership interests in the partnership.
3. A statement of which partner is responsible for any amounts owed to VDP if the pharmacy ceases business or stops accepting Medicaid.
4. A notarized statement indicating which individual has authority to sign a Vendor Drug contract. The statement must indicate the

person's position within the partnership.

OWNERSHIP INFORMATION CONTINUED

LIMITED LIABILITY COMPANY NAME:____

List all members of the Limited Liability Company (LLC). If additional space is needed, attach a separate page for the other members. For LLC's with corporations or partnerships, see corporation or partnership sections for additional required documents.

NAME: ____ SOCIAL SECURITY #: ______________________________

TX DRIVERS LICENSE #: ___________________________ EXPIRATION DATE: ____________D.O.B.:_____________

NAME: ____ SOCIAL SECURITY #: ______________________________

TX DRIVERS LICENSE #: ___________________________ EXPIRATION DATE: ____________D.O.B.:_____________

NAME: ____ SOCIAL SECURITY #: ______________________________

TX DRIVERS LICENSE #: ___________________________ EXPIRATION DATE: ____________D.O.B.:_____________

For LLC's, enclose with this application:
1. Certificate of Account Status -- from Texas Comptroller 800-252-5555
2. Articles of Organization
3. Certificate of Organization
4. Chart of Organizational Structure

CORPORATION NAME: ____

Corporate Charter Number: __________________
You should enclose with this application:
1. Board of Directors Resolution (page 9)
2. Certificate of Incorporation (Texas corporations) -- from Secretary of State 512-463-5555
or Certificate of Authority to do Business in Texas (foreign corporations)– from Secretary of State
3. Certificate of Account Status -- from Texas Comptroller 800-252-5555
4. Chart of Organizational Structure

Changes of Ownership:
Attach with the application the Ownership Transfer Affidavit
The VDP contract is not transferable or assignable. VDP is unable to perform retroactive changes-of-ownership in regards to the contract, therefore VDP must be notified at least ten days before the effective date of the change, as required in Section II F of the contract.

Out of State Pharmacies Located More Than 30 Miles from the Texas State Line: Please attach a statement detailing the additional benefits to the client that you can provide.

In addition to the required documentation for each business type listed above, the Vendor Drug Program may require other documentation. Failure to provide the requested documentation may result in a denial of the application. The pharmacy understands that this application does not authorize participation and creates no obligation on the part of the Program. The Program will determine the contract start date once the application has been received. If the pharmacy is awarded a contract, it is required to keep the information contained in this application current. For questions regarding the Vendor Drug Program or completion of this application, call 1-800-435-4165. For all ownership types, a Direct Deposit Authorization form is available for your convenience and an application for Payee Identification Number form is required. Links to these forms may be found on VDP's Internet web site http://www.hhsc.state.tx.us/HCF/vdp/intraove.html. Also, on the VDP website are pharmacy agreement forms for the Kidney Health Care (KHC) Program, the Children with Special Health Care Needs Program (CSHCN), and the Children's Health Insurance Program (CHIP). Although participation in these programs is voluntary, VDP recommends submission of these agreements along with the VDP application.

______________________	______________________	______________________
Signature	Printed Name	Title

LIST OF OWNERS AND INDIVIDUALS EXERCISING MANAGEMENT OR CONTROL

Source requirement: Title 42, Code of Federal Regulations, Section 455.104 and 455.106

1. Type or print below the name, address, and title of each individual owning 5% or more of the organization, and of each person exercising management or control of the organization. Attach additional pages if more space is needed:

Name	Address	Position	% Ownership

2. Type or print below the name or names of any of the persons listed above who are related to any other person listed above and specify the nature of the relationship:

Name	Relationship

3. Type or print below the legal name of any other business(es) which have, or have had, a Medicaid contract or provider agreement in which business(es) one of the above persons has/had an ownership or control interest:

Name of Business	Address of Business	Person with Ownership or Control	Vendor Number

4. **Have any of the above individuals been convicted of a crime? (circle one) Yes No** (excluding minor traffic violations)

(A) Conviction or convicted - a judgement of conviction or deferred adjudication has been entered against a person by a state or federal court without regard to the pendency of an appeal or referral to any special post-conviction proceeding;

(B) He/She has been found guilty by a Federal, State, or local court;

(C) He/She has entered a plea of guilty or nolo contendere that has been accepted by a Federal, State, or local court; or

(D) He/She has entered a first offender or other program and judgment of conviction has been withheld.

If yes to question 4, please give all relevant facts including the state where the incident occurred:

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Signature

LIST OF PHARMACISTS RESPONSIBLE
FOR PROVIDING PHARMACEUTICAL SERVICES

1. Pharmacist-in-Charge______________________License Number__________ Date of Birth________
2. Other Pharmacist ________________________ License Number___________ Date of Birth________
3. Other Pharmacist _________________________ License Number___________ Date of Birth________
4. Other Pharmacist _________________________ License Number___________ Date of Birth________
5. Other Pharmacist _________________________ License Number___________ Date of Birth________
6. Other Pharmacist _________________________ License Number___________ Date of Birth________

If additional space is needed, please attach a separate page for other pharmacists and license numbers.

Have any of the persons listed above been convicted of a crime? (Circle One) Yes No
Please see the form **List of Owners Exercising Management or Control** for definition of convictions.
If so, please indicate which individual and give all relevant facts, including the state, where the incident occurred:

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Please note that in the event your pharmacy is awarded a contract, you are required to keep the application current, including the list of pharmacists working at the pharmacy.

____
Signature

SOURCE OF PURCHASE INFORMATION

Please indicate your sources of purchase of pharmaceutical products by answering the following questions:

1. Primary Wholesaler: ___________________________

   Secondary Wholesaler: _________________________

2. Direct purchase from manufacturer _______%
3. List companies with whom you have direct accounts:

   ____

4. Co-op or Buying Group: ____
5. Eligible Public Health Entity Buy (Subsection 340B Veteran's Health Care Act 1992) Yes No

For pharmacy chains with multiple locations, the following information is also required:

6. Do you buy through a general purchasing agreement? Yes No
7. If yes, with whom ____

   ____

8. Do you have a warehouse? Yes No
9. Do you have an agreement with your wholesaler to store the drugs for you? Yes No
10. Who owns the product while stored? Pharmacy Wholesaler
11. Do you have one contract/agreement with the wholesaler to serve all of your locations? Yes No
12. Do you allow your pharmacies to make spot purchases outside of the existing wholesaler contract/agreement? Yes No

TYPE OF PHARMACY

1. Is pharmacy located within a hospital? Yes No
   If yes, please reference the name of the hospital ____

2. Is pharmacy located within a medical clinic? Yes No
   If yes, please reference the name of the medical clinic ____

3. Is pharmacy located within an MHMR Hospital Clinic? Yes No
   If yes, please reference the name of the MHMR Hospital Clinic ___________________________________

4. Is pharmacy located within a nursing home? Yes No
   If yes, please reference the name of the nursing home____

5. For pharmacy chains, how many pharmacies do you have in Texas?________ In the U.S.?_________

6. Please reference the days of the week and the hours of operation for the Pharmacy ________________
   (i.e., Monday- Friday, 8:00 a.m.-5:00p.m.)

7. What percentage of your prescriptions do you deliver by mail?____________

8. Does pharmacy exclusively dispense to a particular type of customer, i.e., nursing homes, home health care recipients, or patients with a specific chronic condition? Yes No
   If yes, please specify which type of customer ____

9. Does pharmacy receive public funds other than Vendor Drug and Medicare? Yes No
   If yes, please specify: ____

10. Is the pharmacy a Federally Qualified Health Center? Yes No
    FQHCs are reimbursed by a total encounter rate for all services under the Veterans Health Care Act of 1992.

____
Signature

State of

County of

Before me, the undersigned authority, on this day personally appeared ______________________________ ________________________ known to me to be the person(s) whose name(s) is (are) subscribed to the foregoing instrument and who, being duly sworn by me, states that the above and foregoing information supplied in the instrument is complete, true and correct.

Sworn to and subscribed before me, ____this _____________ day of ____________________, in the year_______.

Notary Public in and for _____________________________

County of ____

TAPE SERVICE BUREAU AND ELECTRONIC CLAIMS SUBMISSION INFORMATION

Pharmacy:____

Address: ____

City, State, Zip: ____

Contact Person and Telephone Number: ____

Second Contact Person and Telephone Number: ____

Is the pharmacy presently open? Yes No

If no, when do you expect to open?____

Do you use a tape service bureau to send you paid claims data? Yes No
Tape service bureaus are payment reconciliation services that use magnetic tapes.

Name of tape service bureau ________________________________

What is your National Council of Prescription Drug Programs (NCPDP) number? _____________________
All NCPDP numbers are seven digits in length and all pharmacies within Texas have NCPDP numbers starting with 45. **If you do not have an NCPDP number, call (480) 477-1000.**

What company designed your software for the on-line submission of Texas Medicaid Vendor Drug Program claims? ___________________________

What company serves as your switch service bureau? _________________________ If your switch/carrier is unknown, call your software company. A switch service bureau is a vendor that receives and transfers claims from contracted pharmacies to the Texas Medicaid Vendor Drug Program.

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Signature

BOARD OF DIRECTORS RESOLUTION
(This page is for CORPORATIONS ONLY)

On the ________________ day of _________________, 20_____ at a meeting of the Board of Directors present, the following resolution was adopted:

BE IT RESOLVED that the Board of Directors of the above corporation does hereby authorize ____ and his/her successors in office to negotiate a contract or contracts with the Texas Health and Human Services Commission and to execute said contract or contracts on behalf of the Corporation for the purpose of participating in the Title XIX Vendor Drug Program under the Texas Medical Assistance Program, and further we do hereby give him/her the power and authority to execute any and all documents incident to this transaction in the Title XIX Vendor Drug Program under the Texas Medical Assistance Program and, in addition, authority to do any and all things necessary to implement, maintain, amend or renew said contracts to assure continued participation in the Title XIX Vendor Drug Program under the Texas Medical Assistance Program.

The above resolution was passed by a majority of those present and voting in accordance with the By-laws and Articles of Incorporation.

I certify that the above and foregoing constitutes a true and correct copy of a part of the minutes of a meeting

of the Board of Directors of _______________________________ held on the ____________ day of

________________________, 20______.

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Secretary

State of
County of

Before me, the undersigned authority, on this day personally appeared ___________________________ known to me to be the person whose name is subscribed to the foregoing instrument and who duly sworn to me, states that the above and foregoing information supplied in this instrument is complete, true, and correct.

Sworn to and subscribed before me, _______________________________________this ____________ day

of ___________________, in the year_______.

Notary Public in and for ____________________________

County of

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