New Home Application

Name of Home____

Address____

City/State/Zip____

Telephone___________________ Fax_______________________

Administrator _______________________________ Maximum Number of Clients _____

Provide different shipping address below if applicable:

____

___Please indicate the times that you use in your facility for:

NOTE: The example times listed are our standard dose times. Please check here __________ to use the standard times.

Daily medications ______ (example 8AM)

Two times daily ______ ______ (example 8AM, 8PM)

Three times daily ______ ______ ______ (example 8AM, 4PM, 8PM)

Four times daily ______ ______ ______ ______ (example 8AM, 12NOON,4PM, 8PM)

Bedtime ______ (example 8PM)

Please indicate preferred medication packaging style:

____ Calendar Cards (single fill) ____ Multifill

Paper or electronic MAR (QuickMAR)? ___________________

Do you want physician order forms sent monthly? _______________________

Would you prefer PRN medications in bottles or count down cards? _______________

How is this home licensed? ____MHMR ___DSS Assisted Living

____ DSS Residential Care ___ Other

Current Pharmacy Provider:____________________________ Contact Number:_____________

Notes: