Logo, company name

Description automatically generated**Community Pharmacy Services Application Form**

***New Pharmacies, Amalgamations or***

***Sale and Purchase of existing Pharmacies***

***Document Control***

|  |  |
| --- | --- |
| **Date** |  |
| **Authorised by** | General Manager Strategy, Commissioning and Population Health |

***Please complete the application form and send it to:***

Community Pharmacy Portfolio Manager

Whanganui District Health Board

Private Bag 3003

Whanganui 4540

or email to [contractadmin@wdhb.org.nz](mailto:contractadmin@wdhb.org.nz)

**Community Pharmacy Services Application**

***New Pharmacies, Amalgamations, Sale and Purchase of existing Pharmacies, addition of services, additional premises and changes in location***

This application will be considered by Whanganui District Health Board (WDHB) in accordance with its *Community Pharmacy Services Commissioning Policy.*

**New Pharmacy Contracts**

Applications for new Pharmacy Contracts will be assessed against the criteria in section 1 and section 2.

**New Pharmacy Services within existing Pharmacy Contracts**

Applications for new pharmacy services within existing pharmacy contracts will be assessed against a reduced set of criteria (identified in the green shaded boxes).

For new pharmacies, Whanganui DHB will offer to contract with the applicant only if the application has achieved a green grade across all relevant areas. If some areas have been graded amber, further information will be sought from the applicant. A red grade will result in an immediate decline.

The grading grid below will be used when assessing the application.

|  |  |
| --- | --- |
| **Evidence Provided** | **Grade** |
| No or inadequate evidence provided with significant issues outstanding | **RED** |
| Inadequate evidence provided – only minor issues remain | **AMBER** |
| Substantial evidence provided | **GREEN** |

A **Supplier Financial Information Form, MOH Preliminary Information for a Licence to Operate Pharmacy** AND **Sector Operations Pharmacy Agreement Application Form** need to be completed by you, if your application is recommended.

See also **TAS Pharmacy Transfer Guide** for further information

<https://tas.health.nz/dhb-programmes-and-contracts/community-pharmacy-programme/publications-resources/#Pharmacycontracts>

***Please note – completing this application form is not an offer and does not constitute a contractual arrangement between us.***

**Section 1: Applicant Details & Core Requirements**

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| 1. **Application Summary**   ***(Required for all applications)*** | |
| This application is for:  *(New, amalgamation, sale and purchase of existing pharmacy, addition of services, addition of premises, change in location)* | Choose an item. |
| Legal Entity Name | *Response* |
| Name or proposed name of Pharmacy | *Response* |
| Location (suburb, street, co-location with medical centre/ surrounding medical practices etc.) | *Response* |
| Contact phone number and email address | Ph:  Email: |
| Responsible Person under Medicines Act 1981 | *Response* |
| Shareholding pharmacist(s) | *Response* |
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| 1. **Optional Services**   ***(Required for all applications, if relevant)*** | | |
| **Optional services** – Please indicate below the optional services you wish to provide  *Note: Inclusion of these services is not guaranteed and will be reviewed as a part of your application* | | |
|  | PH1006 | Opioid substitution treatment (extended methadone) services |
|  | PH1010 | Aseptic pharmacy services |
|  | PH1025 | Sterile manufacturing services |
|  | PH1008 | Clozapine (monitored therapy medicine) services |
|  | PH1036 | Influenza immunisation Services |
|  | PH1028 | Long term conditions (LTC) services |
|  | PH1035 | Community residential care (CRC) services |
|  | PH1029 | Age-related residential care (ARRC) services |
|  | PH1003 | Special foods services |
|  | PH1031 | Community pharmacy anti-coagulation management (CPAMs) services |
|  | PH1011 | Smoking cessation services |
|  | PH1011 | NRT Co-Payment |
|  | PH1018 | Medicines Use review and Adherence Support Services |
|  | PH1019 | Adherence Packaging (in association with Medicines Use Review and Adherence Support Services |
|  | PH1021 | NRT Services |
|  | PH1021 | Nga Taura Tuhono |
|  | PH1021 | Free Contraception - Consultation |
|  | PH1022 | Free Contraception - Co-Payment |
|  | PH1015 | Pharmacy Depot Service |
|  | PH1031 | Community Pharmacy Anti- Coagulation Management Service |
|  | PH1024 | Rural Practice Top Up |
|  | PH1024 | Under 14 After Hours |
|  | PH1024 | Gout Stop Project |
|  | PH1024 | Childhood Rehydration |
| *If any of these services require special certification in order for the pharmacy to deliver these services, please provide evidence of this certification.* | | |

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| 1. **Applicant Details**   ***(required for New Pharmacies, Assignments and Transfer and (where indicated) addition of premises, changes in locations)*** | | |
| **Question** | **Response** | **Grade** |
| Does the responsible person or any of the shareholders hold a current Annual Practicing Certificate, relevant to service delivery in New Zealand? |  |  |
| Has the responsible person or any of the shareholders ever had conditions imposed on their Annual Practicing Certificate (APC) or had an APC cancelled. If answering yes, please provide details. | *Response* |  |
| Has the responsible person or any of the shareholders ever had conditions imposed on their Ministry of Health Pharmacy Licence or had it cancelled. If answering yes, please provide details. | *Response* |  |
| Confirmation that the proposed pharmacy hours of operations or services will not be decreased without written agreement of Whanganui DHB.  (Applies to addition of premises and change in location) | *Response* |  |
| Confirmation that the proposed pharmacy location will not be moved without written agreement of Whanganui DHB (in accordance with clause B.20(1) of the ICPSA).  (Applies to addition of premises and change in location) | *Response* |  |

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| 1. **Reference Checks**   ***(Required for New Pharmacies, Assignments and Transfers)***  As a part of Whanganui DHB’s Due Diligence Process, Whanganui DHB requests your permission to undertake enquiries with other agencies/organisations that you have relationships with. This will include, but is not necessarily limited to regulatory bodies, auditing agencies and other DHBS, for whom you have provided services to.  Please provide details of **two** business referees that you are currently a supplier and /or client of.  Referees must be relevant to the goods services you wish to provide  *(Reference checks will be conducted legally, in an ethical manner)* | |
| **Information Required** |  |
| Referee Details | *Make any comments on additional information provided* |
| Referee Details |  |

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| 1. **Declaration**   ***(Required for all applications)***  I declare that to the best of my knowledge, the information given in this application is true and correct. I understand that by signing below, I am giving permission to Whanganui District Health Board to undertake their assessment process and enquiries. | |
|  | **Signature** |
| Authorised Contact Person  Name: |  |
| Second Signatory (if required)  Name: |  |

**Please attach to this application:**

*(Please note, these documents are not required for applications for additional services)*

* Completed Police Check form for the Responsible Person
* Evidence of ID
* Copy of current APC for the Responsible Person, including any conditions

**Section 2: Strategic Fit**

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| 1. **Provision of accessible services to a population in need of pharmacist services** | | | |
| **Question** | **Response** | | **Grade** |
| **Q1.** Describe the needs of the population being served, how these are currently being met and how your services will meet  the unmet population health needs | *Include consideration of equity and socioeconomic deprivation* | |  |
| **Q2.** What is the proposed location of your services? | *Include information on co-located and nearby services and facilities relating to better population health outcomes, such as healthy eating, healthy exercise, social inclusion, etc* | |  |
| **Q3.** What are your proposed days and hours of operation, including afterhours services? |  | |  |
| **Q4.** List the services that you intend to provide to meet the needs of the population you intend to serve. | *Confirmation that you will provide all PHARMAC Schedule non-section H medications to patients if requested and required; including high cost medications (exemptions may apply as directed by*  *WDHB or PHARMAC)*  *Optional Services in Section 1*  *Provide any additional commentary on other services here* | |  |
| **Q5**. List the current community pharmacy services serving this population, and the gap in the  market | *Provide information about existing pharmacy services in the proposed location - what services, the different services that will be supplied above the*  *existing services, distance to nearest pharmacy(s)* | |  |
| 1. **Delivery of high quality, best practice services** | | | |
| **Question** | **Response** | | **Grade** |
| **Q6.** Provide documents listed in Section one, to demonstrate good character | *Include:*   * *Details of any conditions imposed on an APC* * *Details if an APC has ever been cancelled* * *If you have been a pharmacy owner previously, provide details if a Ministry of Health licence has had conditions applied or cancelled* | |  |
| **Q7.** Provide evidence of systems and processes relevant to meeting the Pharmacy Action Plan |  | |  |
| **Q8.** Describe how your proposed service will resolve identified unmet need in our community and work towards achieving equitable outcomes in the community | *Provide evidence of systems, processes and philosophy relevant to improving health equity, particularly for Māori* | |  |
| **Q9.** Provide details of your workforce | *Provide information on staffing FTE and their qualifications* | |  |
| 1. **A focus on providing integrated patient care** | | | |
| **Question** | **Response** | | **Grade** |
| **Q10.** Describe how you intend to work with other health providers in an integrated manner to ensure continuity of care to patients resulting in better health outcomes | * *Explain you will work with other health care providers to support better health outcomes* * *Demonstrable evidence of support from other health care providers (e.g. primary care) in the proposed community* | |  |
| **Q11.** Describe how you will increase the impact of co-located and nearby services to achieve positive health outcomes for the community | *Information on where the proposed pharmacy will be located, including information on co-located and nearby services and facilities relating to better population health outcomes, such as healthy eating, healthy exercise, social inclusion, etc.* | |  |
| 1. **Sustainability and efficiency of the services** | | | |
| **Question** | **Response** | | **Grade** |
| **Q12.** Please detail your proposed Business Structure |  | |  |
| **Q13.** Provide a copy of your Business Plan | *Include YTD Financial Statements for the last two years, and a projected Cashflow Summary for the next three years.* | |  |
| **Q14.** Outline any other businesses currently owned by the applicant |  | |  |
| **Q15.** Provide financial information to demonstrate the likely sustainability of the business |  | |  |
| **Other supporting information**  ***Please provide any other information that you wish to be considered as part of your application*** | | | |
| **Additional Information Provided** | | **Comments** | |
| *List additional information provided* | | *Make any comments on additional information provided* | |

**Document Check List**

All applications

* Completed application Form

For New Pharmacies

* Completed Police Check form for the Responsible Person
* Evidence of Identification
* Copy of current APC for the Responsible Person (including any conditions)

Further Information may be required **if application is recommended to proceed including**

* A Supplier Financial Information Form
* MOH Preliminary Information for a Licence to Operate Pharmacy
* Sector Operations Pharmacy Agreement Application Form