# Medication Dispensing System

## SERVICE CAPACITY

* 1. Where is your monitoring station located?
  2. Describe your/your agency's capacity to travel for in-home installations, citing any restrictions or limitations.
  3. What is the timespan between referral and installation?
  4. Specify policy for notifying ASAP of any issues encountered that affect, or could affect completion of the authorized service.
  5. Attach copy(ies) of brochure(s)/instructional video(s) featuring unit(s) offered.
  6. Provide a description of how each dispensing unit functions.
  7. Describe each unit's capacity to function in the event of power outage.
  8. Does/do available unit(s) have the capacity to alert monitors/caregivers to missed doses?
  9. How are these alerts communicated?
  10. What language capacities are available in dispensing units offered?
  11. Describe the process for testing in-home equipment.
  12. Describe the process for servicing malfunctioning units.
  13. Is maintenance available weekends and evenings?
  14. What is your company's policy in the event that equipment is damaged or lost?
  15. Describe the process of retrieval of equipment once the consumer and/or service is suspended or terminated.

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1. Attach copy of detailed instructions provided to caregivers who pre-fill and monitor the Medication Dispensing System.
2. Attach blank copy of the detailed, written agreement entered between provider and caregiver.
3. What is your proposed rate for Medication Dispensing System? Describe any additional charges.

## STAFF QUALIFICATIONS

* 1. List qualifications required of those responsible for the processing of referrals, in-home set-up, and supervision of staff (attach job descriptions).
  2. What is your policy for ensuring that those providing services to ASAP consumers are properly screened and trained?

## SUPERVISION

* 1. Describe the procedures for supervision, including frequency and documentation for each position.
  2. Describe the systems and procedures employed to ensure that services are delivered to consumers as authorized.

Employee who completed this form Date:

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| --- | --- | --- | --- | --- | --- |
| EMPLOYEE Records Review | | | | | |
| Provider Date Monitor |  |  |  |  |  |
| Start Date  & Termination Date, if applicable |  |  |  |  |  |
| Number of reference checks |  |  |  |  |  |
| CORI Check |  |  |  |  |  |
| Job Description |  |  |  |  |  |
| TB Testing: Latest date |  |  |  |  |  |
| Ongoing Training |  |  |  |  |  |
| OIG monthly checks |  |  |  |  |  |
| Annual Performance Appraisal: Date |  |  |  |  |  |
| Comments | | | | | |

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| CONSUMER Records Review | | | | | |
| Provider Date Monitor |  |  |  |  |  |
| ASAP Authorization |  |  |  |  |  |
| ID Info – name; address; phone; DOB SAMS ID # |  |  |  |  |  |
| Physician(s) name and phone |  |  |  |  |  |
| Hospital name and phone |  |  |  |  |  |
| Medical/ social diagnosis |  |  |  |  |  |
| Name of current CM |  |  |  |  |  |
| Date of referral/installation |  |  |  |  |  |
| Date of service termination |  |  |  |  |  |
| Date of unit removal |  |  |  |  |  |
| Contact info for caregiver responsible for pre-filling and monitoring |  |  |  |  |  |
| Copy of signed, written agreement between caregiver and provider |  |  |  |  |  |
| Confidentiality notice |  |  |  |  |  |
| Release of information |  |  |  |  |  |
| Documentation of contacts with MD/CM/Care Providers, as needed |  |  |  |  |  |
| Comments | | | | | |
| NOTE: Shaded data elements are only required in the Consumer File if provider is not on Provider Direct. | | | | | |
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