ADMINISTRATIVE OVERVIEW
SERVICE SPECIFIC ATTACHMENT
Medication Dispensing System

I. SERVICE CAPACITY

A. Where is your monitoring station located?

B. Describe your/your agency's capacity to travel for in-home installations, citing any restrictions or limitations.

C. What is the timespan between referral and installation?

D. Specify policy for notifying ASAP of any issues encountered that affect, or could affect completion of the authorized service.

E. Attach copy(ies) of brochure(s)/instructional video(s) featuring unit(s) offered.

F. Provide a description of how each dispensing unit functions.

G. Describe each unit's capacity to function in the event of power outage.

H. Does/do available unit(s) have the capacity to alert monitors/caregivers to missed doses?

I. How are these alerts communicated?

J. What language capacities are available in dispensing units offered?

K. Describe the process for testing in-home equipment.

L. Describe the process for servicing malfunctioning units.

M. Is maintenance available weekends and evenings?

N. What is your company's policy in the event that equipment is damaged or lost?

O. Describe the process of retrieval of equipment once the consumer and/or service is suspended or terminated.

P. Attach copy of detailed instructions provided to caregivers who pre-fill and monitor the Medication Dispensing System.

Q. Attach blank copy of the detailed, written agreement entered between provider and caregiver.

R. What is your proposed rate for Medication Dispensing System?
$
Describe any additional charges.

II. STAFF QUALIFICATIONS

A. List qualifications required of those responsible for the processing of referrals, in-home set-up, and supervision of staff (attach job descriptions).

B. What is your policy for ensuring that those providing services to ASAP consumers are properly screened and trained?

III. SUPERVISION

A. Describe the procedures for supervision, including frequency and documentation for each position.

B. Describe the systems and procedures employed to ensure that services are delivered to consumers as authorized.

Provider employee who completed this form
Name: Date:

SERVICE SPECIFIC ON-SITE REVIEW

Medication Dispensing System

Please note the documents and records which will be required for the Consumer files and/or Employee files to be reviewed at the time of On Site Evaluation

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					

SERVICE SPECIFIC ON-SITE REVIEW

Medication Dispensing System

Please note the documents and records which will be required for the Consumer files and/or Employee files to be reviewed at the time of On Site Evaluation

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. Otherwise the PD Demonstrator will be asked to illustrate “on screen”.					

Name and Position of Provider Direct Demonstrator	