

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.

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- 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.

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Provider employee who completed this form

Name: \_\_\_\_\_

Date: \_\_\_\_\_

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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					

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

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<b>Name and Position of Provider Direct Demonstrator</b>	
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