Home Delivery of Medication

* = required field

I. General Policies and Procedures

A. Describe the services you are able to provide.*

_____

B. After receiving a call from the ASAP to initiate service, describe your agency's procedures. Include expected time frames, and average time between ASAP referral and the start of service to the consumer. *

_____

C. Are there any restrictions on providing service?*

_____

D. How is your agency informed about changes in consumer medications or schedules?*

_____

E. Describe your policy for notifying the ASAP when you wish to change/alter an authorized medication or schedule.*

_____

F. Describe your process for reporting any consumer concerns to the ASAP, including medication non-compliance such as returned or missing medication. *

_____

G. Describe your policy for notifying the ASAP agency about problems encountered that affect completion of authorized services (such as no answer at the door, etc.).*

_____

H. Describe your procedure for consumer /caregiver non-payment of medications.*

_____

I. Describe your procedure for ensuring staff sensitivity to elders.*

_____

J. Describe your process for responding to consumers who speak a language not spoken by your monitoring staff; are hearing impaired; or have a diagnosis of Alzheimer's Disease or Related Dementia (ADRD)?*

_____

K. Describe your policy for delays due to weather and holidays. How are consumers and the ASAP notified?*

_____

L. How do you inform the consumer if a different generic medication is used?*

_____

II. Personnel Procedures

A. Describe your procedure for the orientation and training of Pharmacy Technicians, and drivers. *

_____

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

_____

C. Is medication delivery available on weekends, evenings, and holidays?*

_____

D. Describe the manner and frequency of staff supervision and performance evaluations.*

_____

E. What is your proposed monthly flat rate for Home Delivery of Medication? Describe any additional charges.*

_____

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

_____

If needed, attach supplementary documents here. Please clearly identify which question(s) pertain to the attachment(s)
Attachment Name(s):

_____

Provider employee who completed this form *
Name: _____ Date: _____