Medication Dispensing System

* = required field

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.*
Attachment Name(s):

_____

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.*
Attachment Name:

_____

Attach blank copy of the detailed, written agreement entered between provider and caregiver.*
Attachment Name: _____

Q. 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.*

_____

Attach supplemental documentation here. Please clearly identify which question(s) the attachment(s) pertain to. *

Attachment Name: _____

Provider employee who completed this form*

Name: _____ Date: _____