ADMINISTRATIVE OVERVIEW
SERVICE SPECIFIC ATTACHMENT

Home Delivery of Medication

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 are confused.

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.

ADMINISTRATIVE OVERVIEW
SERVICE SPECIFIC ATTACHMENT

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.

Provider employee who completed this form

Name: _____ Date: _____