

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.

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- 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.

Provider employee who completed this form

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

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