State of Illinois
Illinois Department on Aging

Community Care Program

PROVIDER APPLICATION FOR AUTOMATED MEDICATION DISPENSER SERVICE

INSTRUCTIONS:
PLEASE PRINT OR TYPE (NO PENCIL).

PART A: APPLICANT INFORMATION

Administrative Office Contact Information:			
1. LEGAL NAME OF AGENCY →			
Address	→	Street:	
	→	City:	
	→	State:	Zip Code:
Contact Person at Administrative Office	→	Name:	
	→	Title:	
	→	Phone: ( )	Ext:
	→	Fax: ( )	
E-mail Address for Contact Person	→	E-mail:	
Business Hours of Administrative Office	→		
Is your Automated Medication Dispenser agency a subsidiary of a parent organization?		❑ Yes ❑ No	
If yes, Name and Address of parent organization.			
Name of Parent Organization:	→		
Address of Parent Organization:	→	Street:	
	→	City:	
	→	State:	Zip Code:

PART B: PROPOSED SERVICE AREA

❑ **STATEWIDE**

❑ **COUNTY/COUNTIES SERVED (SPECIFY BELOW)**

❑ Adams	❑ Crawford	❑ Grundy	❑ Kendall	❑ Massac	❑ Pike	❑ Stephenson
❑ Alexander	❑ Cumberland	❑ Hamilton	❑ Knox	❑ McDonough	❑ Pope	❑ Tazewell
❑ Bond	❑ DeKalb	❑ Hancock	❑ Lake	❑ McHenry	❑ Pulaski	❑ Union
❑ Boone	❑ DeWitt	❑ Hardin	❑ LaSalle	❑ McLean	❑ Putnam	❑ Vermilion
❑ Brown	❑ Douglas	❑ Henderson	❑ Lawrence	❑ Menard	❑ Randolph	❑ Wabash
❑ Bureau	❑ DuPage	❑ Henry	❑ Lee	❑ Mercer	❑ Richland	❑ Warren
❑ Calhoun	❑ Edgar	❑ Iroquois	❑ Livingston	❑ Monroe	❑ Rock Island	❑ Washington
❑ Carroll	❑ Edwards	❑ Jackson	❑ Logan	❑ Montgomery	❑ Saline	❑ Wayne
❑ Cass	❑ Effingham	❑ Jasper	❑ Macon	❑ Morgan	❑ Sangamon	❑ White
❑ Champaign	❑ Fayette	❑ Jefferson	❑ Macoupin	❑ Moultrie	❑ Schuyler	❑ Whiteside
❑ Christian	❑ Ford	❑ Jersey	❑ Madison	❑ Ogle	❑ Scott	❑ Will
❑ Clark	❑ Franklin	❑ JoDaviess	❑ Marion	❑ Peoria	❑ Shelby	❑ Williamson
❑ Clay	❑ Fulton	❑ Johnson	❑ Marshall	❑ Perry	❑ Stark	❑ Winnebago
❑ Clinton	❑ Gallatin	❑ Kane	❑ Mason	❑ Piatt	❑ St. Clair	❑ Woodford
❑ Coles	❑ Greene	❑ Kankakee				

COOK COUNTY:

- ❑ Sub-area 01: 60626, 60640, 60645, 60659, 60660
- ❑ Sub-area 02: 60625, 60630, 60631, 60646, 60656
- ❑ Sub-area 03: 60634, 60635, 60639, 60641, 60666
- ❑ Sub-area 04: 60613, 60614, 60618, 60647, 60657
- ❑ Sub-area 05: 60601, 60602, 60603, 60604, 60605, 60606, 60607, 60610, 60611, 60622, 60661
- ❑ Sub-area 06: 60615, 60616, 60637, 60649, 60653
- ❑ Sub-area 07: 60609, 60623, 60629, 60632, 60638
- ❑ Sub-area 08: 60617, 60619, 60627, 60628, 60633, 60827
- ❑ Sub-area 09: 60620, 60621, 60636, 60643, 60652, 60655
- ❑ Sub-area 10: 60608, 60612, 60624, 60644, 60651

SUBURBAN COOK COUNTY:

❑ Barrington	❑ Cicero	❑ Leyden	❑ North Proviso	❑ Palatine	❑ Riverside	❑ Thornton
❑ Berwyn	❑ Elk Grove	❑ Lyons	❑ Northfield	❑ Palos	❑ Schaumburg	❑ Wheeling
❑ Bloom	❑ Evanston	❑ Maine	❑ Norwood Park	❑ Rich	❑ South Proviso	❑ Worth
❑ Bremen	❑ Hanover	❑ New Trier	❑ Oak Park	❑ River Forest	❑ Stickney	
❑ Calumet	❑ Lemont	❑ Niles	❑ Orland			

If the geographic area is smaller than a county or township, identify municipalities or relevant portions of the county(ies), township(s) and/or sub-area(s)/zip code(s):

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PART C: AUTOMATED MEDICATION DISPENSER UNIT INFORMATION

(For questions 1–9 refer to the AMD unit. Please specify which unit you are applying for certification and attach required documentation for **each** unit).

Unit Name _____ **Product Code** _____

❑ UL60950 (Attached) or ❑ UL60950-1 (Attached)
❑ Class I (Attached) or ❑ Class II (Attached) or ❑ Class III (Attached)

1. As stated in Section 240.1543(b)(1)(2) the AMD unit meets the following specifications and operating features:

a. the unit must be portable, waterproof, mechanical system, ❑ **Yes** ❑ **No**
b. all the cords and interfaces needed for installation, ❑ **Yes** ❑ **No**
c. an internal battery capable of operating as a power source for a minimum of three years, ❑ **Yes** ❑ **No**
d. a battery back-up that charges automatically when unit is powered and maintains a charge for at least 12 hours when the electric power to the AMD unit is interrupted, ❑ **Yes** ❑ **No**
e. a low battery charge signal, ❑ **Yes** ❑ **No**
f. components certified as appropriate by the Federal Communications Commission (FCC) under 47 CFR Parts 15 and 68; and, ❑ **Yes** ❑ **No** **(Attach: supporting documentation if appropriate or state why not appropriate)**
g. appropriate Underwriters Laboratories (UL) safety standards certification for battery powered technology equipment, ❑ **Yes** ❑ **No**
h. ability to be loaded, programmed and changed to add and remove prescriptions, ❑ **Yes** ❑ **No**
i. local or remote accessibility to the AMD unit in order to program it in accordance with physician orders for medication administration; the unit must allow medication to be dispensed at least 4 times a day, ❑ **Yes** ❑ **No**
j. to alert the participant at the times programmed for dispensing medication. ❑ **Yes** ❑ **No**

2. As stated in Section 240.1543(b)(2)(B), the AMD unit has the ability to be filled with medications by the responsible party including:

a. holding at least 7 days' supply of prescription medications, ❑ **Yes** ❑ **No**
b. holding 8 or more different medications in individual compartments, ❑ **Yes** ❑ **No**
c. access to medication for an early dose option; and, ❑ **Yes** ❑ **No**
d. locking after the medication is loaded. ❑ **Yes** ❑ **No**

(Attach: Descriptive brochure showing the above specifications for each unit to be certified)

3. As stated in Section 240.1543(b)(2)(C), the AMD unit has the ability to alert the participant when it is time to take medications at least every 5 to 10 minutes for at least 60 minutes until the dose is taken or the dose is locked, including:

a. using verbal, auditory or visual prompts such as flashing lights and audible tones or verbal instructions, which may also provide messages to take medication that cannot be stored in the machine based on participant's needs, ❑ **Yes** ❑ **No**
b. dispensing medications at the correct time of day in the correct combinations and in the correct quantities; and, ❑ **Yes** ❑ **No**
c. easy adjustment of the volume on auditory or verbal features. ❑ **Yes** ❑ **No**

Unit Name	Product Code

4. As stated in Section 240.1543(b)(2)(D), the AMD unit uses HIPAA compliant methods of communication with the participant/authorized representative/responsible party including:

a. notification when battery is low, unit is jammed or if participant has not taken the medication within 90 minutes of the prescribed time, and ❑ **Yes** ❑ **No**

b. contact by the unit or call center to the participant/authorized representative/ responsible party to assure adherence or needed intervention. ❑ **Yes** ❑ **No**

5. As stated in Section 240.1543(b)(2)(E), the AMD unit has the ability to securely transmit information and provide data to the participant/authorized representative/responsible party, the Department or its designees. ❑ **Yes** ❑ **No**

6. As stated in Section 240.1543(b)(3), the AMD unit is capable of conducting automatic battery testing and transmitting the results through the AMD unit to the support center on an ongoing basis. ❑ **Yes** ❑ **No**

7. As stated in Section 240.1543(b)(4), regardless as to whether or not the AMD unit is a Class I and II medical device, it is subject to the General controls mandated by the Federal Food and Drug Administration. ❑ **Yes** ❑ **No**

8. As stated in Section 240.1543(b)(5), the AMD unit has adaptations for operation by individuals who have functional, hearing or visual impairments, and language barriers at no extra cost to the participant. ❑ **Yes** ❑ **No**

9. As stated in Section 240.1543(c), the AMD unit has the following:

a. an integrated unit that connects to either a rotary dial or touchtone telephone via a modular jack or wireless/cellular system that does not interfere with the normal use of the telephone or other devices using the telephone line such as Emergency Home Response Services, ❑ **Yes** ❑ **No**

b. an Underwriters Laboratory (UL) approved plug as the connector to a standard residential electrical outlet for its power supply, ❑ **Yes** ❑ **No**

c. an easily identifiable “ready” light to verify whether the batteries on the base unit are charged, ❑ **Yes** ❑ **No**

d. a battery that automatically charges whenever the base unit is powered and that maintains a charge for at least 12 hours when the electric power to the base unit is interrupted, ❑ **Yes** ❑ **No**

e. transmission capability to signal the support center if the base unit battery fails or has a low charge, or electric power to the base unit is interrupted, ❑ **Yes** ❑ **No**

f. configuration that allows signaling services through more than one unit for more than one participant in a residence, ❑ **Yes** ❑ **No**

g. an easy method to control the volume of the unit, ❑ **Yes** ❑ **No**

h. give both an audible and visual technology and lighting cues to provide medication alerts; and, ❑ **Yes** ❑ **No**

i. repeated alerts or messages until the medication is taken, or until the time limit on reminders is met, at which time the dose is transferred to a locked storage area and the responsible party is notified of the missed medication dose. ❑ **Yes** ❑ **No**

(Attach: Descriptive brochure showing the above specifications for each unit to be certified).

PART D: SUPPORT CENTER AND BACK-UP SUPPORT CENTER INFORMATION

1. I have read and understand as stated in Section 240.1543(d)(1) that the AMD support center must have back-up monitoring capacity to take over all medication dispenser notification functions, monitoring and technical support functions. ❑ **Yes** ❑ **No**

2. I have read and understand as stated in Section 240.1543(d)(3) that the AMD support center **and** back-up center equipment **must:**

a. monitor the AMD system for the receipt of incoming signals from installed and programmed AMD units in participants' residence, ❑ **Yes** ❑ **No**

b. direct an appropriate response to the receipt of a signal immediately via texts/emails to the responsible party and call the responsible party within 90 minutes of missed medications and within eight hours of power interruptions and outages, ❑ **Yes** ❑ **No**

c. provide technical support as required, 24-hours-a-day, 365 days a year, ❑ **Yes** ❑ **No**

d. identify each participant and simultaneously record all communication between the participant/authorized representative/responsible party and the support center as applicable, for all signals including missed medication doses, test transmissions and fault conditions, ❑ **Yes** ❑ **No**

e. display, print and archive the participant identifier, date, time, communication and response for each signal, test and fault condition, which must be maintained for at least a 3-year period of time for quality control and liability purposes, ❑ **Yes** ❑ **No**

f. have an uninterruptible power supply (UPS) back-up that will automatically take over system operation in the event electric power to the support center is interrupted, other type of malfunction occurs, or repairs are needed. The back-up power supply must be sufficient to operate the entire system for a minimum of 7 calendar days, ❑ **Yes** ❑ **No**

g. have separate and independent primary and back-up systems, computer servers, databases, and other components to provide an uninterruptible monitoring system in the event of equipment malfunction, ❑ **Yes** ❑ **No**

h. perform self-diagnostic testing for malfunctions in equipment in a participant's residence and at the support center, and for fault conditions in the primary and back-up operating systems and power supply at the support center, that could interfere with receiving and responding to signals, such as non-operational AMD units; messages sent from the AMD unit to the participant/authorized representative/responsible party without confirmation of receipt, telephone line outages; power loss; etc., ❑ **Yes** ❑ **No**

i. capability to centrally generate medication compliance data and reports as requested by the Department, ❑ **Yes** ❑ **No**

j. have quality management systems that include tracking and trending of data, response times and dispositions; and, ❑ **Yes** ❑ **No**

k. maintain appropriate certification by the FCC under 47 CFR Parts 15 and 68. ❑ **Yes** ❑ **No**

3. I have read and understand as stated in Section 240.1543(d)(2) that the back-up monitoring center must be at a location different from the primary center, on a different power grid system and on a different telephone trunk line. ❑ **Yes** ❑ **No**

4. Main Support Center(s) Information:			
Address	→	Street:	
	→	City:	
	→	State:	Zip Code:
Contact Person at Administrative Office	→	Name:	
	→	Title:	
	→	Phone: ( )	Ext:
	→	Fax: ( )	
E-mail Address for Contact Person	→	E-mail:	
Address	→	Street:	
	→	City:	
	→	State:	Zip Code:
Contact Person at Administrative Office	→	Name:	
	→	Title:	
	→	Phone: ( )	Ext:
	→	Fax: ( )	
E-mail Address for Contact Person	→	E-mail:	
Address	→	Street:	
	→	City:	
	→	State:	Zip Code:
Contact Person at Administrative Office	→	Name:	
	→	Title:	
	→	Phone: ( )	Ext:
	→	Fax: ( )	
E-mail Address for Contact Person	→	E-mail:	

(Attach additional sheet(s) if necessary)

5. Back-up Monitoring Center(s) Information:			
Address	→	Street:	
	→	City:	
	→	State:	Zip Code:
Contact Person at Administrative Office	→	Name:	
	→	Title:	
	→	Phone: ( )	Ext:
	→	Fax: ( )	
E-mail Address for Contact Person	→	E-mail:	
Address	→	Street:	
	→	City:	
	→	State:	Zip Code:
Contact Person at Administrative Office	→	Name:	
	→	Title:	
	→	Phone: ( )	Ext:
	→	Fax: ( )	
E-mail Address for Contact Person	→	E-mail:	
Address	→	Street:	
	→	City:	
	→	State:	Zip Code:
Contact Person at Administrative Office	→	Name:	
	→	Title:	
	→	Phone: ( )	Ext:
	→	Fax: ( )	
E-mail Address for Contact Person	→	E-mail:	

(Attach additional sheet(s) if necessary)

PART E: SERVICE SPECIFICATIONS

1. I have read and understand **all** applicable Community Care Program rules set forth in 89 Illinois Administrative Code Part 240. ❑ **Yes** ❑ **No**

2. I have read and understand the definition of Automated Medication Dispenser as stated in Section 240.237 of the CCP rules. ❑ **Yes** ❑ **No**

3. I have read and understand as stated in Section 240.237 that the specific components of AMD service must include:

a. the Automated Medication Dispenser unit shall be installed in the participant's residence with all connectors, parts and equipment necessary for installation and adaptations for operation by individuals who have functional, hearing, or visual impairments or who exhibit language barriers. ❑ **Yes** ❑ **No**

b. the Automated Medication Dispenser unit shall be delivered and installed into a functioning telephone or wireless/cellular system in the participant's residence within 48 hours after the referral when the participant is at imminent risk of institutionalization and within 15 calendar days from the date of referral in other instances. This timeline can be extended if requested by the participant/authorized representative/responsible party. ❑ **Yes** ❑ **No**

c. this service shall not be subcontracted and shall be provided by trained employees who will identify themselves by picture identification that can be verified by the participant/authorized representative. ❑ **Yes** ❑ **No**

d. delivery and installation of the AMD unit may include coordination of emergency home response service (see Section 240.235) ❑ **Yes** ❑ **No**

e. my agency will provide training to the participant/authorized representative and responsible party on the proper use of the AMD system at the time of installation and subsequently when needed. ❑ **Yes** ❑ **No**
(Attach: Copy of training material)

f. my agency will comply with all verbal and written instruction specified in Rule Section 240.237. ❑ **Yes** ❑ **No**
(Attach: Specs on equipment, explanation of website/programming changes for medication changes, missed dose notification process, testing and monitoring)

g. my agency shall ensure that the participant/authorized representative reviews his or her responsible party designation at least every 6 months. Any changes must be sent to the Care Coordination Unit (CCU) within 5 calendar days. ❑ **Yes** ❑ **No**
(Attach: Policy)

h. my agency shall obtain the signature of the participant/authorized representative and responsible party to verify that the AMD equipment was delivered and installed and that the instructions and demonstration were given and understood by the participant/ authorized representative and responsible party. ❑ **Yes** ❑ **No**

i. my agency will own and operate a separate support center and a back-up support center. ❑ **Yes** ❑ **No**

j. my agency will maintain adequate local staffing levels of qualified personnel to conduct and provide necessary administrative activities, installation, in-home training, equipment monitoring, technical support, medication program changes and repair requests in a timely manner. ❑ **Yes** ❑ **No**
(Attach: Training module for personnel, policy on replacing equipment, job descriptions and qualifications for call monitoring staff, list of Illinois installers with geographic area served)

k. my agency will repair or replace the AMD equipment within 24 hours after receiving a malfunction report. ❑ **Yes** ❑ **No**

l. my agency will alert the participant/authorized representative and responsible party when electric power to the AMD equipment has been interrupted and the unit is operating on a standby power source. ❑ **Yes** ❑ **No**
(Attach: Policy)

m. my agency will notify the CCU after activation of the AMD unit and working to resolve complaints within 1 business day and within 2 calendar days if the service cannot be initiated or must be terminated. ❑ **Yes** ❑ **No**
(Attach: Policy)

n. my agency will maintain records in accordance with Section 240.1544. ❑ **Yes** ❑ **No**

o. my agency will make available individual reports on missed medication doses, power and battery status and other reporting features on an ongoing basis to the responsible party and Care Coordinators. ❑ **Yes** ❑ **No**
(Attach: Example of this report)

p. my agency will provide access to individual and aggregate reports, consumer satisfaction surveys and AMD system performance measures on an ongoing basis to authorized persons through a HIPAA-compliant website. ❑ **Yes** ❑ **No**
(Attach: Report)

q. my agency will provide ad hoc reports upon request to the Department. ❑ **Yes** ❑ **No**

4. I will comply with all Administrative Requirements for Certification specified in CCP Rule Section 240.1505. ❑ **Yes** ❑ **No**

5. I have read and understand as stated in Section 240.1544(a) that in order for my agency to qualify for certification my agency must:

a. meet the administrative requirements and minimum administrative standards under Sections 240.1505 and 240.1510, ❑ **Yes** ❑ **No**

b. meet the applicable responsibilities imposed on provider agencies under the Community Care Program set forth in Section 240.1520, ❑ **Yes** ❑ **No**

c. meet the certification requirements under Sections 240.1600 or 240.1605, ❑ **Yes** ❑ **No**

d. provide assurance that its equipment and support center are in continual compliance with the business and technology requirements imposed on provider agencies under Section 240.1543; and, ❑ **Yes** ❑ **No**

e. provide assurance that its business operations comply with the service, staffing and training requirements under Section 240.237. ❑ **Yes** ❑ **No**

6.	I have read and understand as stated in Section 240.1544(a)(6) that management staff of the AMD service provider shall be required to complete Illinois Department on Aging AMD management training prior to the award of a CCP AMD provider agreement from the Department. ❑ **Yes** ❑ **No**
7.	I have read and understand as stated in Section 240.1544(a)(7) that the annual audit report required by the Department must include an Independent Certified Public Accountant's opinion concerning the provider's compliance with financial Reporting requirements. ❑ **Yes** ❑ **No**
8.	I have read and understand as stated in Section 240.1544(a)(8) that the provider must accept all correspondence from the Department and maintain adequate records for administration, audit, budgeting, evaluation, operation and planning efforts by the Department in offering the AMD service through the Community Care Program. ❑ **Yes** ❑ **No**
9.	I have read and understand as stated in Section 240.1544(a)(9) that the AMD provider shall comply with all applicable Federal, State, and local laws, regulations, rules, service standards and policies or procedures pertaining to the AMD provider in its business operations and to the services provided under the CCP. ❑ **Yes** ❑ **No**
10.	I have read and understand as stated in Section 240.1544(b) that if an AMD provider is not able to meet these administrative requirements, then the Department shall deny its request for a certification of qualifications under Section 240.1600. ❑ **Yes** ❑ **No**

PART F: APPLICANT SIGNATURE PAGE

By my **notarized** signature below,

I certify that information in this Automated Medication Dispenser Service Provider Certification Application is true, accurate, and complete to the best of my knowledge as of the time of signing; that the agency is fiscally sound; that the service proposed herein complies with all Rules of the Community Care Program and will be available on an equal basis in a nondiscriminatory manner without reprisal or retaliation to all eligible participants regardless of age; ancestry; citizenship; color; creed or religion; familial status; gender, sex or sexual orientation; genetic information; marital status; military status or unfavorable discharge from military service; national origin or race; order of protection status; parental status; physical or mental disability; political beliefs; or any other protected classification under applicable civil rights laws; that the agency is in compliance with all applicable Federal, State, and local laws, regulations, and ordinances; and that the agency will cooperate with Department officials in verifying information and hereby authorizes any third party with relevant information bearing on the certification decision to release such information to the Department upon request.

I understand that knowingly providing false information or omitting information may result in denial of certification, decertification or debarment as a service provider under the Community Care Program, termination of any provider agreement and/or other enforcement under federal and state law.

I also agree to update this information as necessary so that it remains true, accurate, and complete while this application is being processed.

_____ _____
Signature of Authorized Representation Date

_____
Name/Title **(Type or Print)**

NOTARY CERTIFICATE

STATE OF _____)
) SS:
COUNTY OF _____)

Subscribed and sworn to before me this _____ day of _____, 20_____.

_____ _____
Signature of Notary Public Printed or typed name of Notary Public

_____ _____
County of residence Date commission expires

Return original and 2 copies of form to: **REMEMBER TO KEEP A COPY FOR YOUR RECORDS**

Illinois Department on Aging
ATTN: Office of Service Development and Procurement
One Natural Resources Way, #100
Springfield, IL 62702-1271

This application is authorized as outlined by the Illinois Act on the Aging. Disclosure of this information is REQUIRED. Failure to provide information could result in denial of certification as a service provider under the Community Care Program.

The Illinois Department on Aging does not discriminate in admission to programs or treatment of employment in government-funded programs, services, or activities in compliance with applicable civil rights laws, policies, and procedures. If you feel you have been discriminated against, you have a right to file a complaint with the Illinois Department on Aging. For information, call the Senior HelpLine: 1-800-252-8966 (Voice); 1-888-206-1327 (TTY).