STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Jewel Mullen, M.D., M.P.H., M.P.A.
Commissioner

Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

Immunization Program

PLEASE COPY THIS FOR ALL HEALTH CARE PROVIDERS

IN YOUR PRACTICE

TO: **All Health Care Providers**

FROM: **Mick Bolduc-Vaccine Coordinator, Connecticut Vaccine Program (CVP)** **MB**

DATE: **November 7, 2013**

SUBJECT: **Re-Enrollment in the Connecticut Vaccine Program**

The primary purpose of this communication is to notify all providers of the need to complete a provider profile and provider agreement form for re-enrollment in the CVP.

Re-enrollment Process

In order to participate in the Connecticut Vaccine Program each provider must complete and submit a provider profile and provider agreement form on a yearly basis. The re-enrollment process allows us to verify and update provider shipping information as well as to estimate the amount of vaccine that will need to be supplied for the upcoming calendar year. As vaccine accountability continues to become increasingly important on the federal level, it is vital that the patient enrollment numbers your office submits on the provider profile are as accurate as possible. These numbers determine the amount of federal and CHIP funding the CVP receives on an annual basis.

The completed provider profile and signed provider agreement forms must be submitted to the Connecticut Vaccine Program by December 31, 2013. Meeting this deadline will allow all providers who are accepted into the program to continue receiving state supplied vaccine on an uninterrupted basis. Please be sure to include your Provider Identification Number (PIN) on both the agreement and profile forms. The completed forms can be faxed to (860) 509-8371.

As always, if you have any questions, please feel free to contact the Connecticut Vaccine Program at (860) 509-7929.

Connecticut Vaccine Program

2014 Provider Profile

Completed forms can be FAX to: 860-509-8371 or email: DPH.IMMUNIZATIONS@ct.gov

All public and private health care providers who receive vaccine from the Connecticut Vaccine Program **(CVP)** must complete this form. This document provides shipping information and helps to determine the amount of vaccine to be supplied. The form is also used to compare estimated vaccine needs with actual vaccine supply. The Connecticut Vaccine Program will keep this record on file with the SIGNED **"Provider Agreement"**. The Provider Profile form must be updated annually or if: (1) the number of children change, or (2) the address of the facility changes. **Complete one Provider Profile for each office/site/satellite.**

PIN Number
____ ____ ____ ____

Federal Employer Tax ID	Please Check One
____ ____ ------ ____ ____ ____ ____ ____ ____ ____	☐ Re-Enrolling in CVP ☐ New Provider

Facility Shipping Address (Vaccine Delivery Location)

Facility Name		Primary Vaccine Coordinator Contact Name and Title	
		Back Up Vaccine Coordinator Name and Title	
Vaccine Shipping Address (No P.O. Boxes)		Floor or Suite #	Email Address
City	Zip Code	Direct Phone Number to Contact Person	Fax Number

Facility Mailing Address (If Different From Delivery Location)

Mailing Address	
City	Zip Code

Office Days and Hours Staff Available to Receive Vaccine Shipments

Monday	Tuesday	Wednesday	Thursday	Friday

Include any time during normal business hours when the office is closed and will not accept vaccine deliveries.

List of All Providers Who Administer Vaccines

First & Last Name	Title	CT License #	Medicaid Billing #	Group Billing #

Type of Facility (check one)

- ☐ Local Health Department
- ☐ Federally Qualified Health Center (FQHC) or Federally Funded Rural Health Clinic (RHC)
- ☐ School Based Health Center Clinic
- ☐ STD/HIV Clinic
- ☐ Drug Treatment Facility
- ☐ Family Planning Clinic
- ☐ Birthing Hospital
- ☐ Private Practice (Individual or Group)
- ☐ Hospital Clinic
- ☐ Other (please specify)

Specialty (check one)

- ☐ Pediatrics
- ☐ Family Medicine
- ☐ Primary Care
- ☐ OB/GYN
- ☐ Internal Medicine
- ☐ Allergy
- ☐ Urgent Care Center
- ☐ Other (please specify)

Patient Enrollment

All practices must provide total patient enrollment numbers by age group and insurance status in order to receive vaccine from the CVP. New providers can give an estimate.

Total Patient Enrollment

	Birth to 1 yr.	1 - 6 yrs.	7 -18 yrs.	Total
Total Number of **All** Patients in your practice who will be administered state supplied vaccine:				

Patient Insurance Status Do not count a patient in more than one category or use percentages.

The total of 1-6 below must equal the total patient enrollment listed above

	Birth to 1 yr.	1 - 6 yrs.	7 - 18 yrs.	Total
1 Number of Privately Insured Patients				
2 Number of Medicaid Enrolled Patients (HUSKY A)				
3 Number of Patients Without Insurance				
4 Number of Patients who are American Indian or Alaskan Native				
5 Number of S-CHIP Enrolled Patients (HUSKY B)				
6 Number of Underinsured Patients				

Data Source

What data source was used to determine the total number of patients and insurance status provided above:

☐ Immunization Information System ☐ Billing System ☐ Electronic Health/Medical Records ☐ Other, specify _____

Storage Units

Please indicate the type of storage unit(s) used to store state supplied vaccine (check all that apply)

☐ Stand Alone Refrigerator Unit ☐ Stand Alone Freezer Unit ☐ Single Door Refrigerator & Freezer Unit (Dormitory Style)

☐ Double Door Refrigerator and Freezer Unit (top/bottom or side by side)

Temperature Monitors

Indicate type of temperature monitors used in storage

☐ CVP Supplied Continuous Read Dickson Thermometer

☐ Dial Thermometer

☐ Liquid Temperature Probe

☐ Data Logger

☐ Specify:

PLEASE remember to sign the *accompanying "Provider Agreement"* .

State of Connecticut, Department of Public Health; 410 Capitol Avenue, M.S. # 11MUN Hartford, CT 06134-0308
Phone: 860-509-7929
Fax: 860-509-8371

Revised 11/13

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Connecticut Vaccine Program
Provider Agreement

PIN:_____

(To be provided by CVP)

The Undersigned Provider hereby agrees to participate in the Connecticut Vaccine Program (hereafter the "program" or the "CVP") through its below identified facility, which will receive CVP supplied vaccines, which includes Vaccines for Children(VFC) and other state supplied vaccines and agrees that he or she:

1. Shall not impose a charge for the cost of the vaccine received through this program; however may collect a reasonable administration fee per dose given. The administration fee collected for uninsured or underinsured children cannot exceed $21 per dose; the administration fee for all Medicaid recipients shall be the fee schedule established by the Department of Social Services; and the administration fee for private insurance patients can be up to the maximum allowed per the insurance company's policy.

2. Shall not deny administration of a CVP supplied vaccine to an established CVP eligible child due to the inability of the child's parent, guardian or individual of record to pay an administration fee.

3. Shall not bill the client or a third party (e.g., insurance company or Medicaid) for vaccines that the provider has received from the CVP.

4. Shall provide the Department of Public Health ("DPH") with the number of children 0-18 years of age expected to need immunizations at this facility/practice for the 12-month period beginning on January 1, 2014. This information shall be submitted to the DPH on the Provider Profile form as part of the annual CVP enrollment process.

5. Shall for each immunization encounter indicate on the most current DPH Patient Eligibility Screening Record (www.ct.gov/dph) whether a patient who is 18 years old or younger is VFC eligible, non-VFC eligible or covered by S-CHIP (as defined on the most current DPH Eligibility Criteria form); and shall administer CVP provided vaccines to each patient who is eligible to receive CVP provided vaccines as determined by the most current DPH Eligibility Criteria form.

6. Shall comply with the immunization schedules, dosages and contraindications that are approved by the Advisory Committee on Immunization Practices (ACIP), unless (a) in the exercise of medical judgment, and in accordance with accepted medical practice, such compliance is deemed to be medically inappropriate; or (b) such compliance contradicts Connecticut General Statutes §§ 10-204a, 19a-7f or Regulations of Connecticut State Agencies §19a-79-6a(e) regarding immunizations, school and daycare immunization requirements and religious or medical exemptions.

7. Shall provide Vaccine Information Statements (VIS) with each vaccine administered and maintain records in accordance with the National Childhood Vaccine Injury Act (NCVIA), which includes reporting clinically significant adverse events to the Vaccine Adverse Event Reporting System (VAERS).

8. Shall report adverse vaccine reactions (i.e., reactions requiring medical attention) to DPH (by phone or fax) within 2 weeks of the adverse reaction.

9. Shall maintain all CVP-related records for at least three (3) years and, if requested, shall make such records available to DPH or the U.S. Department of Health and Human Services (DHHS).

10. Shall comply with CVP requirements for vaccine ordering, including, without limitation, timely and properly completing the State Vaccine Order Form, which may be periodically amended, including the information regarding the number of vaccine doses administered per age group per vaccine.

11. Shall maintain good vaccine storage and handling practices to avoid vaccine wastage, and shall promptly report to the CVP any vaccine wastage or loss. Providers shall not permanently store vaccines in a dorm style refrigeration unit. Providers are financially liable for all vaccines ordered through the CVP and will make every attempt to administer or transfer to another provider every dose ordered from the program.

12. Shall permit only appropriately licensed personnel to administer vaccines to patients.

13. Shall grant DPH access to the practice or clinic to conduct program and patient record reviews.

14. Understands that should my staff, my representative or I access VTrckS, I am bound by the Centers for Disease Control and Prevention's ("CDC") terms of use for interacting with the online ordering system. I further agree to be bound by any applicable federal laws, regulations or guidelines related to accessing a CDC system and ordering publically funded vaccines.

15. Understands that before my staff, my representative or I access VTrckS, I will identify each person who is authorized to order vaccines for me and maintain a record identifying all such authorized persons. If someone becomes authorized or is no longer authorized to order for me, I will inform the CDC of such change within twenty-four (24) hours of such change.

16. Certifies that my identification is represented correctly on this agreement and the Provider Profile.

17. Understands that either party may terminate this agreement at any time for any reason, including, without limitation, provider's failure to comply with all CVP requirements. The provider shall give thirty (30) days written notice before terminating this agreement.

18. Shall properly return any unused CVP vaccine if the provider or CVP opts to terminate this agreement.

This Agreement is effective upon execution and acceptance into the CVP until December 31, 2014 unless terminated sooner as provided herein. Except for continuing to receive publicly purchased vaccines, the foregoing provisions of this agreement shall survive its termination. This agreement supersedes any previous written or oral agreement.

This Agreement is subject to Executive Order No. 3 of Governor Thomas J. Meskill, promulgated June 16, 1971, concerning labor employment practices; Executive Order No. 17 of Governor Thomas J. Meskill, promulgated February 15, 1973, concerning the listing of employment openings; and Executive Order No. 16 of Governor John G. Rowland, promulgated August 4, 1999, concerning violence in the workplace. This Agreement may also be subject to Executive Order 7C of Governor M. Jodi Rell, promulgated July 13, 2006, concerning contracting reforms and Executive Order 14 of Governor M. Jodi Rell, promulgated April 17, 2006, concerning procurement of cleaning products and services, in accordance with their respective terms and conditions. All of these Executive orders are incorporated into

and made a part of this Agreement as if they had been fully set forth in it. At the provider's request, the Agency shall provide a copy of these Orders to the provider.

THE UNDERSIGNED, BEING THE PROVIDER OR HAVING THE SPECIFIC AUTHORITY TO BIND THE PROVIDER TO THE TERMS OF THIS AGREEMENT, HEREBY AGREES TO ABIDE BY AND COMPLY WITH ALL OF THE STIPULATIONS, CONDITIONS AND TERMS SET FORTH HEREIN INCLUDING REPRESENTING THAT THE PROVIDER WILL COMPLY WITH THE NONDISCRIMINATION AGREEMENTS AND WARRANTIES OF CONNECTICUT GENERAL STATUTES §§ 4a-60 AND 4a-60a, AS AMENDED.

_____

Provider Name (must be a practitioner who is authorized by state law to administer pediatric vaccines) (Print)

_____

Facility Name (print)

_____

Provider's Title (Must be an Authorized Officer, Owner or Partner of facility) (Print**)**

_____ _____

Signature Date

This record is to be submitted to and kept on file at the Connecticut Vaccine Program and must be updated at least once annually. A copy of this form shall be retained at the provider's office. It shall be shared with all relevant persons at the facility/practice including persons administering vaccines, staff responsible for billing procedures and any others determined at the provider site that need to know the information herein.