



PREVENTION PARTNERSHIP PROVIDER ENROLLMENT

NORTH DAKOTA DEPARTMENT OF HEALTH

SFN 58496 (12-2008)

**Centers for Disease Control and Prevention
Grant Number H23/CCH822552-01-1
Immunization and Vaccines for Children Grant**

**CFDA No. 93.268
Immunization Grants
Budget Period 2008**

Provider I.D. Number

To participate in the Prevention Partnership Program and receive state and federally procured vaccine provided to my facility at no cost, I agree to the following conditions, on behalf of myself and all the practitioners, nurses and others associated with this medical office, group practice, managed care organization, community/migrant/rural clinic, health department or other health delivery facility of which I am the medical director or equivalent:

1. I will screen patients at all immunization encounters for eligibility and administer Vaccine for Children (VFC) or state-supplied vaccine only to individuals who meet the following criteria:
 - a. Is 18 years of age or younger
 - AND**
 - b. Is VFC vaccine-eligible
 - i. Is an American Indian or Alaska Native.
 - ii. Is enrolled in Medicaid.
 - iii. Has no health insurance.
 - iv. Is underinsured (a child whose health insurance benefit plan does not cover a particular vaccine). Federally Qualified Health Centers (FQHC) or Rural Health Clinics (RHC) or providers with a Letter of Agreement with a FQHC are the only providers who may vaccinate underinsured children.
 - OR**
 - c. Is considered state-supplied vaccine-eligible based on the most current North Dakota Vaccine Coverage Table.
2. I will comply with the immunization schedule, dosage, and contraindications that are established by the ACIP and included in the VFC program unless:
 - a. In my medical judgment, and in accordance with accepted medical practice, the provider deems such compliance to be medically inappropriate.
 - b. The particular requirements contradict state law, including those pertaining to religious and other exemptions.
3. I will maintain all records (including patient screening forms, temperature logs, etc.) related to the VFC program for a minimum of three years and make these records available to public health officials including the North Dakota Department of Health (NDDoH) or U.S. Department of Health and Human Services (DHHS) upon request.
4. I will immunize eligible children with VFC or state-supplied vaccine at no charge to the patient for the vaccine.
5. I will not charge a vaccine administration fee to VFC children or state-supplied vaccine recipients that exceeds the administration fee cap of \$13.90 per vaccine dose. I will accept the reimbursement for immunization administration set by the state Medicaid agency for vaccine administered to children enrolled in Medicaid.
6. I will not deny administration of a VFC or state-supplied vaccine to a patient because the child's parent or guardian or the patient is unable to pay the administration fee.
7. I will distribute the most current Vaccine Information Statements (VIS) each time a vaccine is administered and maintain records in accordance with the National Childhood Vaccine Injury Compensation Act (NCVIA) which includes reporting clinically significant adverse events to the Vaccine Adverse Event Reporting System (VAERS).
8. I will comply with the NDDoH requirements for ordering, vaccine accountability, and vaccine management. (See Vaccine Management Plan, Vaccine Fraud and Abuse Policy and the Vaccine Loss Policy.)
 - a. I agree to operate within the VFC program in a manner intended to avoid fraud and abuse.
 - b. I will comply with the North Dakota Immunization Program's Vaccine Loss Policy, which includes maintaining proper storage and handling procedures for vaccine and reimbursing for any vaccine lost due to negligence by employees of my facility.
9. I will document demographic, VFC-eligibility, and immunization information on a Vaccine Administration Record (VAR) or Patient Eligibility Screening Form and in the North Dakota Immunization Information System (NDIIS).
10. I will allow NDDoH staff to conduct site visits for review of vaccine administration procedures, vaccine storage procedures and coverage level assessments.
11. The NDDoH may terminate this agreement at any time for failure to comply with these requirements, or I may terminate this agreement at any time for any reason. If I terminate, I agree to return all unused VFC and state-supplied vaccine.

Provider Signature:	Date:
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This record is to be submitted and kept on file at the North Dakota Department of Health Immunization Program and must be updated in accordance with state policy.

For State Use Only:	
Immunization Program Representative:	Date Certified for Prevention Partnership:



PREVENTION PARTNERSHIP PROGRAM PROVIDER PROFILE
 NORTH DAKOTA DEPARTMENT OF HEALTH
 SFN 58495 (12-2008)

Provider I.D. Number:

All Prevention Partnership providers must complete this form. This document provides shipping information and helps the state determine the amount of vaccine supplied through the Vaccines for Children Program. One person per practice should complete this form.

Physician/Provider			
Last Name:		First Name:	
		Middle Initial:	
Facility/Clinic Name:			
Street Address:		City:	State:
			Zip Code:
Contact Name(s):		Title:	
Telephone Number:		Fax Number:	
Email Address(es): If you need more space, please write on the back of this page.			
Are you currently using the North Dakota Immunization Information System (NDIIS)? <input type="checkbox"/> YES <input type="checkbox"/> NO			
Type of Facility (Please check only one box):		<input type="checkbox"/> Pharmacy	<input type="checkbox"/> Indian Health Services
<input type="checkbox"/> Private Hospital Based Clinic		<input type="checkbox"/> Corrections Facility	<input type="checkbox"/> Substance Abuse
<input type="checkbox"/> Private Practice		<input type="checkbox"/> FQHC/ RHC	<input type="checkbox"/> Other Private Facility
<input type="checkbox"/> Private Hospital		<input type="checkbox"/> Public Health Department	<input type="checkbox"/> Other Public Facility
<input type="checkbox"/> HIV/STD Clinic			
Vaccine Delivery Address (If different from above):			
Street Address:		City:	State:
			Zip Code:
Provider Estimates			
For the 12-month period beginning January 1, 2009 , estimate the number of children, including out of state children, who will receive VFC vaccinations at your health facility by age group. Only count a child once in each 12-month period--no matter the number of visits.			
< 1 Year Old	1-6 Years	7-18 Years	Total
VFC Eligibility by Category			
	< 1 Year Old	1-6 Years	7-18 Years
			Total
Enrolled in Medicaid			
No Health Insurance			
American Indian			
Underinsured			
Total: should equal provider estimates (above)			
Type of data used to determine profile:	<input type="checkbox"/> Benchmarking	<input type="checkbox"/> Registry	
	<input type="checkbox"/> Provider Encounter Data	<input type="checkbox"/> Dose Administered	
	<input type="checkbox"/> Medicaid Claims Data	<input type="checkbox"/> Other	
For State Use Only:			
Immunization Program Representative:		Date Certified for Prevention Partnership:	



FROZEN VACCINE STORAGE CERTIFICATION

NORTH DAKOTA DEPARTMENT OF HEALTH
SFN 58498 (12-2008)

Provider Name/Facility:		Provider ID Number:	
Street Address:	City:	State:	Zip Code:
Contact:	Telephone Number:		
Shipping Information (If Different Than Above):		NO POST OFFICE BOXES	
Street Address:	City:	State:	Zip Code:

THE FOLLOWING SECTION MUST BE COMPLETED TO RECEIVE FROZEN VACCINE

Can Freezer Maintain an Average Temperature of +5°F or -15°C or Colder? (Please circle)	YES	NO
Does Freezer Have an Exterior, Insulated Door? (Please circle) NOTE: DO NOT USE DORM-STYLE REFRIGERATORS	YES	NO
What Type of Thermometer is Used in the Freezer?		
Is the Thermometer Used Certified in Accordance with National Institute of Standards and Technology (NIST) or the American Society for Testing and Materials (ASTM)?	YES	NO
Signature of Person Completing Form:	Date:	

For State Use Only:	
Immunization Program Representative:	Date Certified for Prevention Partnership: