

MEMO

TO: North Dakota Prevention Partnership Providers

FROM: Tatia Hardy
Vaccines For Children/AFIX Coordinator

RE: Prevention Partnership Re-Enrollment/
2012 Prevention Partnership Manual
Mandatory Reporting for All Providers

DATE: March 23, 2012

Annually, all providers currently enrolled in the Prevention Partnership Program are required to renew their enrollment in this program. Please complete and return the originals of the **Provider Enrollment, Provider Profile** and **Vaccine Storage Certification** forms to the NDDoH by **April 27, 2012.**

Updated policies, including the Vaccine Coverage Table, Vaccine Loss Policy, Vaccine Management Plan, and Fraud and Abuse Policy are included in the packet. Updated program forms, such as the vaccine order form and vaccine administration record are available on our website at www.ndhealth.gov/Immunize/Providers/Forms.

The following instructions pertain to each form:

PROVIDER ENROLLMENT FORM (Yellow)

The chief physician or medical director who signs standing orders for immunizations is required to sign the Provider Enrollment Form. All other persons with prescription-writing authority who administer state-supplied vaccine must be listed on the reverse side of the Provider Enrollment form. Hospitals do not need to list all physicians on the reverse side. If provider information changes (i.e., providers join or leave the practice), it must be reported to the NDDoH Immunization Program as soon as possible. **Providers should read the enrollment form in its entirety and ensure that all program requirements are being met by the facility. Compliance with program requirements will be assessed at provider site visits, at a minimum of every other year.**

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PROVIDER PROFILE FORM (Salmon)

Please indicate any changes in the contact person's name, address, or any special delivery instructions using the Provider Profile Form. Your VFC population has been estimated for you using data from the North Dakota Immunization Information System (NDIIS). If you feel these numbers are inaccurate, please contact me.

The Immunization Program is asking all Prevention Partnership providers for their current e-mail addresses on the Provider Profile. E-mail will be used to inform providers of new recommendations and other important information in the ever-changing world of immunizations. If your facility does not have e-mail capabilities, please indicate this on the Provider Profile.

VACCINE STORAGE CERTIFICATION (Green)

In order to receive state-supplied vaccine, the storage certification form must be completed including facility address, shipping and storage and handling information.

If you have any questions, please contact the NDDoH Immunization Program at 701.328.3386 or toll-free at 800.472.2180.

Thank you for your participation in this important program.

Enclosures



PREVENTION PARTNERSHIP PROVIDER ENROLLMENT

NORTH DAKOTA DEPARTMENT OF HEALTH

SFN 58496 (12-2011)

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 Vaccines 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), the North Dakota State Auditor or the Auditor's designee, 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 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 requirements for ordering, vaccine accountability, and vaccine management as outlined in the current North Dakota Immunization Program Vaccine Management Plan, Fraud and Abuse Policy, and Vaccine Loss Policy. I agree to operate within the VFC program in a manner intended to avoid fraud and abuse.
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.
12. I agree that all records, regardless of physical form, and the accounting practices and procedures of my facility relevant to this agreement are subject to examination by the North Dakota Department of Health, North Dakota State Auditor or the Auditor's designee.
13. Should my staff, representative, or I access VTrckS, I agree to be bound by CDC's 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 publicly funded vaccines.
14. In advance of any VTrckS access by my staff, representative or myself, I will identify each member of my staff or representative who is authorized to order vaccines on my behalf. In addition, I will maintain a record of each staff member who is authorized to order vaccines on my behalf. If changes occur, I will inform CDC within 24 hours of any change in status of current staff members or representatives who are no longer authorized to order vaccines, or the addition or any new staff authorized to order on my behalf. I certify that my identification is represented correctly on this provider enrollment form.

Provider Signature (must be M.D. or D.O.):	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:
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PROVIDER ENROLLMENT - ADDITIONAL PROVIDERS WITHIN PRACTICE
NORTH DAKOTA DEPARTMENT OF HEALTH
SFN 58494 (01-2011)

Last Name/First Name/ Middle Initial	Medical License Number	Medicaid Provider Number	Title (MD, DO, ND, NP, PA) <u>Note:</u> Provider must have prescription writing privileges	Specialty (Pediatrics, Family Medicine, General Practitioner, Other-Please Specify)

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



PREVENTION PARTNERSHIP PROGRAM PROVIDER PROFILE

NORTH DAKOTA DEPARTMENT OF HEALTH
SFN 58495 (12-2011)

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 (VFC) Program. Review the information below and add or make changes as necessary.

Facility/Clinic Name:				
Street Address:	City:	State:	Zip Code:	
Primary Contact:		Email Address:		
Backup Contact:		Email Address:		
Telephone Number:		Fax Number:		
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"/> Private hospital-based clinic <input type="checkbox"/> Private practice <input type="checkbox"/> Private hospital <input type="checkbox"/> Pharmacy <input type="checkbox"/> Corrections facility <input type="checkbox"/> FQHC/RHC		<input type="checkbox"/> Public health department <input type="checkbox"/> HIV/STD clinic <input type="checkbox"/> Indian Health Services (IHS) <input type="checkbox"/> Substance abuse <input type="checkbox"/> Other private facility <input type="checkbox"/> Other public facility		
Vaccine Delivery Address (If different from above):				
Street Address:	City:	State:	Zip Code:	
Provider Estimates				
The numbers below are estimates of the number of children who will receive VFC vaccinations at your facility for the 12-month period beginning January 1, 2012. These numbers were determined using 2011 data from the NDIIS.				
VFC Eligibility by Category				
	< 1 Year Old	1-6 Years	7-18 Years	Total
Enrolled in Medicaid				
No Health Insurance				
American Indian				
Underinsured				
Total:				
For State Use Only:				
Immunization Program Representative:		Date Certified for Prevention Partnership:		



VACCINE STORAGE CERTIFICATION
 NORTH DAKOTA DEPARTMENT OF HEALTH
 SFN 58498 (12-2011)

Provider I.D. Number:

Facility/Clinic Name:

Contact:

Telephone Number:

THE FOLLOWING SECTION MUST BE COMPLETED TO RECEIVE VACCINE

What type of storage units are used to store refrigerated vaccines? (Check all that apply)

- Stand alone refrigerator
- Dorm-style refrigerator/freezer
- Combined refrigerator/freezer with single door
- Combined refrigerator/freezer with separate external refrigerator and freezer doors (i.e. household-style appliance)

What type of thermometer is used in the refrigerator(s)? (Check all that apply)

- Standard fluid-filled
- Continuous recording
- Minimum/maximum
- Dial
- Digital
- Other (please specify):

What type of storage units are used to store frozen vaccines? (Check all that apply)

- Stand alone freezer
- Dorm-style refrigerator/freezer
- Combined refrigerator/freezer with single door
- Combined refrigerator/freezer with separate external refrigerator and freezer doors (i.e. household-style appliance)
- N/A – facility does not administer vaccines requiring freezer storage

What type of thermometer is used in the freezer(s)? (Check all that apply)

- Standard fluid-filled
- Continuous recording
- Minimum/maximum
- Dial
- Digital
- Other (please specify):

Are the thermometers used certified and calibrated in accordance with National Institute of Standards and Technology (NIST) or the American Society for Testing and Materials (ASTM)? **Note: Must have certificates of calibration for all thermometers in vaccine storage units containing state-supplied vaccine.**

YES

NO

Signature of Person Completing Form:

Date:

For State Use Only:

Immunization Program Representative:

Date Certified for Prevention Partnership: