

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)

A handwritten signature in black ink, appearing to read "Mick Bolduc".

DATE: December 15, 2014

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 Connecticut Vaccine Program (CVP) for calendar year 2015.

Re-enrollment Process

In order to participate in the CVP 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 (HUSKY B) funding the CVP receives on an annual basis.

You will notice that the language in the provider agreement form has been revised. The Centers for Disease Control and Prevention is now mandating that all states use their standardized agreement form. The CVP does not have the ability to change any of the language on the form.

The completed provider profile and signed provider agreement forms must be submitted to the Connecticut Vaccine Program by January 31, 2015. Meeting this deadline will allow all providers 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 or e-mailed to DPH.IMMUNIZATIONS@ct.gov.

In addition to faxed information, the provider agreement requests that the email addresses of the primary and back-up vaccine coordinators be included to ensure receipt of all CVP communications. If additional staff would like to receive CVP communications, we now have an electronic alert system to notify individuals who have signed up when information is sent out. Directions to sign up for e-alerts are included in this packet.

As always, if you have any questions, please feel free to contact me at (860) 509-7940.



Connecticut Vaccine Program 2015 Provider Profile

Completed forms can be FAXED to: 860-509-8371 or EMAILED to: 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.**

Federal Employer Tax ID _____	Please Check One Re-Enrolling in CVP <input type="checkbox"/> New Provider <input type="checkbox"/>	PIN (If re-enrolling pin is required) _____
Facility Name _____		

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.

Type of Facility (check one)

<input type="checkbox"/> Local Health Department <input type="checkbox"/> Federally Qualified Health Center (FQHC) or Federally Funded Rural Health Clinic (RHC) <input type="checkbox"/> School Based Health Center <input type="checkbox"/> STD/HIV Clinic <input type="checkbox"/> Drug Treatment Facility <input type="checkbox"/> Family Planning Clinic	<input type="checkbox"/> Birthing Hospital <input type="checkbox"/> Private Practice (Individual or Group) <input type="checkbox"/> Hospital Clinic <input type="checkbox"/> Other (please specify) Specialty (check one) <input type="checkbox"/> Pediatrics <input type="checkbox"/> Family Medicine	<input type="checkbox"/> Primary Care <input type="checkbox"/> OB/GYN <input type="checkbox"/> Internal Medicine <input type="checkbox"/> Allergy <input type="checkbox"/> Urgent Care Center <input type="checkbox"/> Other (please specify)
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Patient Enrollment and Insurance Status 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. Do not count a patient in more than one category and DO NOT use percentages. **Rows numbered 1 through 6 must equal the total patient enrollment by age group in row 7.**

	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				
7. Total Number of All Patients in your practice who will be administered state supplied vaccine (must equal the sum total for rows 1-6 above)				

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 _____

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
 Other _____

Are you interested in registering for VTrkS (Vaccine Tracking System)? VTrkS is a web based vaccine ordering system developed by CDC.

Yes please send me information

PLEASE remember to sign the accompanying "Provider Agreement"



**Connecticut Vaccine Program
2015 Provider Agreement**

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FACILITY INFORMATION

Facility Name:			PIN:
Facility Address:			
City:	County:	State:	Zip:
Telephone:		Fax:	
Shipping Address (if different than facility address):			
City:	County:	State:	Zip:

MEDICAL DIRECTOR OR EQUIVALENT

Instructions: *The official registered health care provider signing the agreement must be a practitioner authorized to administer pediatric vaccines under state law who will also be held accountable for compliance by the entire organization and its providers with the responsible conditions outlined in the provider enrollment agreement. The individual listed here must sign the provider agreement.*

Last Name, First, MI:	Title:	Specialty:
License #:	Medicaid #:	Employer Identification #: (optional):

Provide Information for second individual as needed (for pharmacists only):

Last Name, First, MI:	Title:	Specialty:
License #:	Medicaid #:	Employer Identification #: (optional):

VACCINE COORDINATOR

Primary Vaccine Coordinator* Name:	
Telephone:	Email: (NOTE: this email address will receive CVP communications)
Completed annual training: <input type="radio"/> Yes <input type="radio"/> No	Type of training received: a) Site visit b) CDC on-line modules c) Other/specify:
Back-Up Vaccine Coordinator* Name:	
Telephone:	Email: (NOTE: this email address will receive CVP communications)
Completed annual training: <input type="radio"/> Yes <input type="radio"/> No	Type of training received: a) Site visit b) CDC on-line modules c) Other/specify:

*The primary vaccine coordinator is the person at the office who has primary responsibility for ordering, monitoring, and ensuring the quality of vaccines at the practice; the back-up vaccine coordinator has responsibility in the vaccine coordinator's absence.



**Connecticut Vaccine Program
2015 Provider Agreement**

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PROVIDER AGREEMENT

To receive publicly funded vaccines at no cost, I agree to the following conditions, on behalf of myself and all the practitioners, nurses, and others associated with the health care facility of which I am the medical director or equivalent:

1.	I will annually submit a provider profile representing populations served by my practice/facility. I will submit more frequently if 1) the number of children served changes or 2) the status of the facility changes during the calendar year.
2.	<p>I will screen patients and document eligibility status at each immunization encounter for VFC eligibility (i.e., federally or state vaccine-eligible) and administer VFC-purchased vaccine by such category only to children who are 18 years of age or younger who meet one or more of the following categories:</p> <p>A. Federal Vaccine-eligible Children (VFC eligible)</p> <ol style="list-style-type: none"> 1. Are an American Indian or Alaska Native; 2. Are enrolled in Medicaid; 3. Have no health insurance; 4. Are underinsured: A child who has health insurance, but the coverage does not include vaccines; a child whose insurance covers only selected vaccines (VFC-eligible for non-covered vaccines only). Underinsured children are eligible to receive VFC vaccine only through a Federally Qualified Health Center (FQHC), or Rural Health Clinic (RHC) or under an approved deputization agreement. <p>B. State Vaccine-eligible Children</p> <ol style="list-style-type: none"> 1. In addition, to the extent that my state designates additional categories of children as “state vaccine-eligible”, I will screen for such eligibility as listed in the addendum to this agreement and will administer state-funded doses to such children. <p>Children aged 0 through 18 years that do not meet one or more of the eligibility federal vaccine categories (VFC eligible), are not eligible to receive VFC-purchased vaccine.</p>
3.	<p>For the vaccines identified and agreed upon in the provider profile, I will comply with immunization schedules, dosages, and contraindications that are established by the Advisory Committee on Immunization Practices (ACIP) and included in the VFC program unless:</p> <ol style="list-style-type: none"> a) In the provider's medical judgment, and in accordance with accepted medical practice, the provider deems such compliance to be medically inappropriate for the child; b) The particular requirements contradict state law, including laws pertaining to religious and other exemptions.
4.	I will maintain all records related to the vaccine program for a minimum of three years and upon request make these records available for review. Vaccine records include, but are not limited to, vaccine screening and eligibility documentation, billing records, medical records that verify receipt of vaccine, vaccine ordering records, and vaccine purchase and accountability records.
5.	I will immunize eligible children with publicly supplied vaccine at no charge to the patient for the vaccine.
6.	<p><u>VFC Vaccine Eligible Children</u> I will not charge a vaccine administration fee to non-Medicaid federal vaccine eligible (uninsured or under-insured) children that exceeds the administration fee cap of \$21.00 per vaccine dose. For Medicaid children, I will accept the reimbursement for immunization administration set by the state Medicaid agency or the contracted Medicaid health plans.</p> <p><u>State Vaccine Eligible Children</u> For private insurance patients I will accept the reimbursement for immunization administration up to the maximum allowed per the insurance company's policy.</p>



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7.	I will not deny administration of a publicly purchased vaccine to an established patient because the child's parent/guardian/individual of record is unable to pay the administration fee.
8.	I will distribute the current Vaccine Information Statements (VIS) each time a vaccine is 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).
9.	I will comply with the requirements for vaccine management including: <ul style="list-style-type: none"> a) Ordering vaccine and maintaining appropriate vaccine inventories; b) Not storing vaccine in dormitory-style units at any time; c) Storing vaccine under proper storage conditions at all times. Refrigerator and freezer vaccine storage units and temperature monitoring equipment and practices must meet Connecticut Vaccine Program storage and handling requirements; d) Returning all spoiled/expired public vaccines to CDC's centralized vaccine distributor within six months of spoilage/expiration
10.	<p>I agree to operate within the VFC program in a manner intended to avoid fraud and abuse. Consistent with "fraud" and "abuse" as defined in the Medicaid regulations at 42 CFR § 455.2, and for the purposes of the VFC Program:</p> <p>Fraud: is an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law.</p> <p>Abuse: provider practices that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to the Medicaid program, (and/or including actions that result in an unnecessary cost to the immunization program, a health insurance company, or a patient); or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program.</p>
11.	I will participate in VFC program compliance site visits including unannounced visits, and other educational opportunities associated with VFC program requirements.
12.	<p>Should my staff, representative, or I access VTrckS, I agree to:</p> <ul style="list-style-type: none"> a) 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 publically funded vaccines, and b) 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 the Connecticut Vaccine Program 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 of any new staff authorized to order on my behalf. I certify that my identification is represented correctly on this provider enrollment form.
13.	<p>For pharmacies, urgent care, or school located vaccine clinics, I agree to:</p> <ul style="list-style-type: none"> a) Vaccinate all "walk-in" VFC-eligible children and b) Will not refuse to vaccinate VFC-eligible children based on a parent's inability to pay the administration fee. <p>Note: "Walk-in" refers to any VFC eligible child who presents requesting a vaccine; not just established patients. "Walk-in" does not mean that a provider must serve VFC patients without an appointment. If a provider's office policy is for all patients to make an appointment to receive immunizations then the policy would apply to VFC patients as well.</p>
14.	I agree to replace vaccine purchased with state and federal funds that are deemed non-viable due to provider negligence on a <u>dose-for-dose</u> basis.
15.	I understand this facility or the Connecticut Vaccine Program may terminate this agreement at any time. If I choose to terminate this agreement, I will properly return any unused state and federal vaccine as directed by the Connecticut Vaccine Program.



Connecticut Vaccine Program
2015 Provider Agreement

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By signing this form, I certify on behalf of myself and all immunization providers in this facility, I have read and agree to the vaccine enrollment requirements listed above and understand I am accountable (and each listed provider is individually accountable) for compliance with these requirements.

Medical Director or Equivalent Name (print):

Signature:

Date:

Name (print) *Second individual as needed:*

Signature:

Date:

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Please be reminded that the law of the State of Connecticut provides protection against discrimination in employment, public accommodation, housing and other activities on the basis of on the basis of

race,

color,

religious creed, religion, creed

age (at any age),

sex (which includes but is not limited to sexual harassment, pregnancy, breast feeding, etc.),

gender identity or expression,

sexual orientation,

marital status (including opposite-sex marriage and same-sex marriage),

national origin,

ancestry,

genetic information,

present or past history of mental disability,

intellectual disability,

learning disability, and

physical disability (including chronic physical conditions), and

lawful source of income.

See Connecticut General Statutes §46a-51 et seq. If you have any questions regarding this, please contact the Commission on Human Rights and Opportunities using the contact information below.

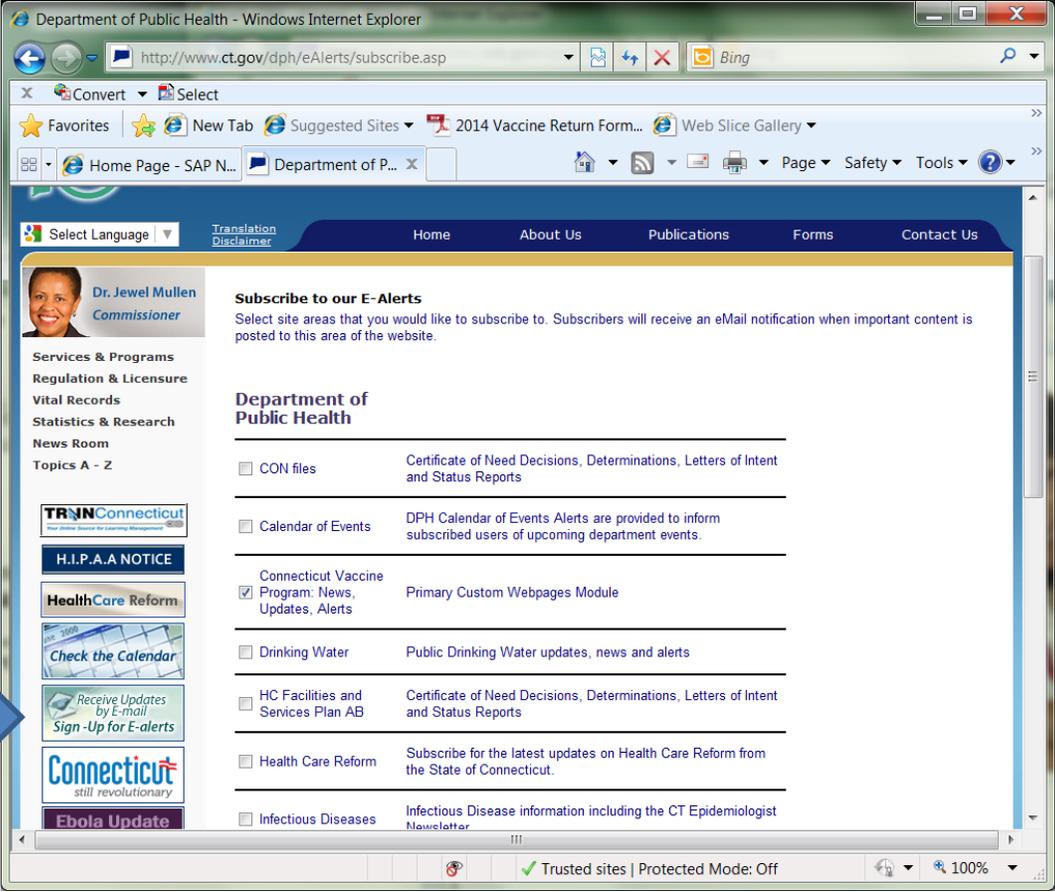
Commission on Human Rights and Opportunities
25 Sigourney Street, 7th Floor
Hartford, CT 06106
Tel.: (860) 541-3423
Fax.: (860) 246-5265

Do you want to keep your staff informed on the latest news from The Connecticut Immunization Program?

Then Sign up for Email E-Alerts. It's easy. Just click on "Receive Updates by Email" icon on the left-hand side of any Department of Public Health web page. Click Register and submit the "Subscription Registration Form". Check the box to receive updates from "**Connecticut Vaccine Program: News, Updates, Alerts**".

To Get Started Click The Link Below

<http://www.ct.gov/dph/guestaccount/login.asp>



The screenshot shows a web browser window displaying the Connecticut Department of Public Health website. The page is titled "Subscribe to our E-Alerts" and includes a list of subscription options. A blue arrow points to a button in the left sidebar that says "Receive Updates by E-mail Sign-Up for E-alerts".

Subscribe to our E-Alerts
Select site areas that you would like to subscribe to. Subscribers will receive an eMail notification when important content is posted to this area of the website.

Department of Public Health

<input type="checkbox"/>	CON files	Certificate of Need Decisions, Determinations, Letters of Intent and Status Reports
<input type="checkbox"/>	Calendar of Events	DPH Calendar of Events Alerts are provided to inform subscribed users of upcoming department events.
<input checked="" type="checkbox"/>	Connecticut Vaccine Program: News, Updates, Alerts	Primary Custom Webpages Module
<input type="checkbox"/>	Drinking Water	Public Drinking Water updates, news and alerts
<input type="checkbox"/>	HC Facilities and Services Plan AB	Certificate of Need Decisions, Determinations, Letters of Intent and Status Reports
<input type="checkbox"/>	Health Care Reform	Subscribe for the latest updates on Health Care Reform from the State of Connecticut.
<input type="checkbox"/>	Infectious Diseases	Infectious Disease information including the CT Epidemiologist Newsletter

Left Sidebar:

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- Ebola Update