

TEXAS DSHS ADULT SAFETY NET (ASN) PROGRAM- PROVIDER ENROLLMENT FORM

PROVIDER PROFILE FOR PIN: _____

VACCINE STORAGE UNITS

Indicate your **Refrigerator** storage units below:

Type

- | | | |
|---|----------|-------|
| <input type="checkbox"/> Small/Single Exterior Door | Total | |
| <input type="checkbox"/> Stand-Alone Refrigerator | Number | |
| <input type="checkbox"/> Combination | of Units | _____ |
| <input type="checkbox"/> Commercial/Pharmacy Grade | | |

Indicate your **Freezer** storage units below:

Type

- | | | |
|---|----------|-------|
| <input type="checkbox"/> Small/Single Exterior Door | Total | |
| <input type="checkbox"/> Stand-Alone Freezer | Number | |
| <input type="checkbox"/> Combination | of Units | _____ |
| <input type="checkbox"/> Commercial/Pharmacy Grade | | |

Type

- | | | |
|---|----------|-------|
| <input type="checkbox"/> Small/Single Exterior Door | Total | |
| <input type="checkbox"/> Stand-Alone Refrigerator | Number | |
| <input type="checkbox"/> Combination | of Units | _____ |
| <input type="checkbox"/> Commercial/Pharmacy Grade | | |

Type

- | | | |
|---|----------|-------|
| <input type="checkbox"/> Small/Single Exterior Door | Total | |
| <input type="checkbox"/> Stand-Alone Freezer | Number | |
| <input type="checkbox"/> Combination | of Units | _____ |
| <input type="checkbox"/> Commercial/Pharmacy Grade | | |

Dormitory style units are not acceptable for vaccine storage at any time.

PATIENT PROFILE

Please enter the number of adults who received vaccinations at your clinic in the past 12 month period ending: _____

Number of adults, age 19 and older, with no health insurance (uninsured): _____

TYPE OF DATA USED TO DETERMINE PROFILE

(select all that apply)

- | | | |
|--|---|-----------------------------------|
| <input type="checkbox"/> Benchmarking | <input type="checkbox"/> Doses Administered | <input type="checkbox"/> Registry |
| <input type="checkbox"/> Provider Encounter Data | <input type="checkbox"/> Other (specify): _____ | |

PROVIDER LIST

Please list all providers practicing at this facility authorized to write prescriptions or who possess a medical license.

Last Name	First Name	Middle Initial	Title (M.D., D.O., N.P., R.Ph., P.A., C.N.M.)	National Provider Identification	Medical License Number	Specialty (Family Medicine, Pediatrics, etc.)

TEXAS DSHS ADULT SAFETY NET (ASN) PROGRAM- PROVIDER ENROLLMENT FORM
PROVIDER ENROLLMENT AGREEMENT FOR PIN: _____

In order to participate in the Texas Adult Safety Net Program and receive state-supplied vaccines provided to me at no cost, I, on behalf of myself and any and all practitioners associated with this medical office, group practice, health department, community/migrant/rural health clinic, FQHC, or other organization, agree to the following:

1. This office/facility will screen patients for adult vaccine eligibility at all immunization encounters and administer state-purchased vaccine only to adults 19 years of age or older who do not have any health insurance.
2. This office/facility will maintain all records related to the Adult Program for at least five years. If requested, this office/facility will make such records available to the Texas Department of State Health Services (DSHS), the local health department/authority, or the U.S. Department of Health and Human Services.
3. This office/facility will comply with the appropriate vaccination schedule, dosage, and contraindications, as established by the Advisory Committee on Immunization Practices, unless (a) in making a medical judgment in accordance with accepted medical practice, this office/ facility deems such compliance to be medically inappropriate, or (b) the particular requirement is not in compliance with Texas law, including laws relating to religious and medical exemptions.
4. This office/facility will provide the most current Vaccine Information Statements (VIS) to the responsible adult each time a vaccine is administered and maintain records in accordance with the National Childhood Vaccine Injury Act, which includes reporting clinically significant adverse events to the Vaccine Adverse Event Reporting System (VAERS). Signatures are required for informed consent. (The Texas Addendum portion of the VIS may be used to document informed consent.)
5. This office/facility will not charge for vaccines supplied by DSHS and administered to an uninsured adult.
6. This office/facility may charge a vaccine administration fee to eligible patients not to exceed \$25.00 per dose.
7. This office/facility will not deny administration of a state-supplied vaccine to an uninsured adult because of inability to pay an administration fee. Unpaid administration fees will be waived and not submitted for collection actions.
8. This office/facility will comply with the State's requirements for ordering vaccine and other requirements as described by DSHS, and operate within the Adult Program in a manner intended to avoid fraud and abuse.
9. This office/facility or the State may terminate this agreement at any time for failure to comply with these requirements. If the agreement is terminated for any reason this office/facility agrees to properly return any unused vaccine.
10. This office/facility will allow DSHS (or its contractors) to conduct on-site visits as required by DSHS regulations.
11. This office/facility will comply with the requirements for vaccine management in accordance with the Certification of Capacity to Store and Manage Vaccines, and the manufacturer's specifications. State-supplied vaccines will only be stored at the facility stipulated in this agreement, and will not be transferred to another provider without approval of DSHS. I may be required to purchase a new refrigerator or freezer unit if equipment at my practice is deemed inappropriate for vaccine storage or not able to maintain appropriate temperatures.
12. I will identify a vaccine coordinator and a back-up coordinator in my practice who is authorized to order vaccines on my behalf. I will inform the Adult 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. This office will require the vaccine coordinator and back-up coordinator to complete all required federal and state trainings annually. Certificates of course completion will be submitted to our responsible entity (HSR or LHD). This office will keep a copy of all certificates along with documentation of all other educational trainings and will make them available for review during DSHS site visits.

To receive state-supplied vaccines, you must confirm acknowledgement of this agreement.

Provider-in-charge: _____
 (Print) First Name Last Name MI Title (M.D., D.O., N.P., R.Ph., P.A. or C.N.M.†)

Provider-in-charge: _____
 (Signature) Date

† A licensed Medical Doctor, Doctor of Osteopathy, Nurse Practitioner, Registered Pharmacist, Physician Assistant or a Certified Nurse Midwife must sign the Enrollment Form.

TEXAS DSHS ADULT SAFETY NET (ASN) PROGRAM- PROVIDER ENROLLMENT FORM

PROVIDER CERTIFICATION OF CAPACITY FOR PIN: _____

In order to participate in the Adult Safety Net Program and receive state-supplied vaccines provided to me at no cost, I, on behalf of myself and any and all practitioners associated with this medical office, group practice, health department, community/migrant/rural health clinic, FQHC, or other organization, agree to the following:

- 1. Comply with Vaccine Storage Equipment Requirements**
Providers must have appropriate equipment that can store vaccine and maintain proper conditions. Equipment must comply with DSHS vaccine storage equipment requirements. Dormitory refrigerators are not allowed for vaccine storage, under any circumstance. Vaccine storage units must be dedicated to the storage of vaccines. Food and beverages must not be stored in a vaccine storage unit.
- 2. Designate a Vaccine Coordinator**
Designate one fully trained staff member to be the primary vaccine coordinator and at least one back-up person able to perform the same responsibilities as the primary vaccine coordinator in the event that the primary person is unavailable. The signing physician is responsible for ensuring compliance with annual training requirements for the vaccine coordinator, back-up and other clinic staff handling and storing vaccines. Documentation of training must be maintained for the clinic. The Adult Program shall be contacted immediately to report a change in the primary vaccine coordinator or back-up coordinator.
- 3. Follow Established Vaccine Storage Guidelines**
Refrigerator and freezer units will be set up properly. Vaccine shall be stored in its original packaging and positioned 2-3 inches away from walls, floor, and with space for air circulation. State-supplied vaccine and private vaccine will be kept separate and clearly labeled. Within each supply, vaccines will be grouped by type and clearly labeled in designated spaces for each vaccine type. Vaccine will not be stored in the doors, drawers or bins. Thermometers or their probes will be placed in the center of both the refrigerator and freezer. Signs to prevent interruption of power to the vaccine storage units ("Do Not Unplug" warning signs) will be posted on the electrical outlets, and circuit breakers. The wall outlets will be protected by a plug guard to avoid accidental disconnection. No food or drinks will be stored in the units. Water bottles shall be placed in the refrigerator and ice packs in the freezer to stabilize the temperatures.
- 4. Use Certified, Calibrated Thermometers**
Each storage unit must have a National Institute of Standards and Technology (NIST) certified and calibrated thermometer centrally located within each unit. Each device is to be covered by a Certificate of Traceability and Calibration Testing (also known as Report of Calibration). Thermometer calibration must be tested annually by a laboratory with accreditation from an International Laboratory Accreditation Cooperation (ILAC) Mutual Recognition Arrangement (MRA) signatory. Providers are responsible for maintaining Certificates of Traceability and Calibration Testing (also known as Report of Calibration) and must have them available for review. Thermometers deemed no longer accurate within, $\pm 1^{\circ}\text{F}$ ($\pm .5^{\circ}\text{C}$) upon calibration shall be replaced. DSHS recommends the thermometer be digital and have a biosafe glycol-encased probe.
- 5. Store Vaccines at Recommended Temperatures**
Vaccines will be maintained at all times within the recommended ranges. Vaccines stored in the freezer (MMR, MMRV, and Varicella) will be maintained at 5°F (-15°C) or below [aim for 0°F (-20°C) or lower to keep temperatures from getting too warm]. All other vaccines will be stored in a refrigerator maintained at a temperature above 35°F (2°C) and below 46°F (8°C) [aim for 40°F (5°) to keep temperatures from getting too warm or cold].
- 6. Monitor and Record Refrigerator and Freezer Temperatures Twice a Day**
The vaccine coordinator shall monitor and record the temperatures in the refrigerator and freezer twice each day. If other staff will be assigned to monitor the temperatures, they must be trained on the use of the thermometer and how to respond to and document out of range temperatures. The current temperature will be recorded on the DSHS provided temperature logs. The logs will be posted on the vaccine storage unit door or in a nearby, readily accessible location and maintained for review for 5 years. Temperatures must be taken and recorded twice each day, at the beginning and end of the day, even if a continuously recording/graphing thermometer or data logger is in use. If the temperature is identified as out of range, immediate action must be taken to prevent spoilage of the vaccine and to correct improper vaccine storage condition. This action must be documented on the temperature log and the Adult Program must be contacted immediately.

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7. **Clearly Identify State-Supplied Vaccine from Privately Purchased Vaccine**
State-supplied vaccine and privately purchased vaccine will be kept separate and clearly labeled to allow easy identification and prevent use on ineligible patients. Vaccines will be labeled either state or private for clear identification and ideally, kept on different shelves to minimize potential for confusion. Accurate and separate stock records (purchase invoices) of both state and private supplied vaccines must be maintained and be available for review upon request.
8. **Maintain and Rotate Stock**
Inventory management shall be conducted by the practice's vaccine coordinator or designee at least once a month and before ordering vaccine. State-supplied vaccine stock must be maintained in accordance with actual vaccine need. Vaccine stock will be rotated to place the vaccine with the shortest expiration date for use first. The Adult Program will be notified of any vaccine that will expire within the next 90 days. Vaccine will be maintained in its original packaging until it is used. Spoiled and expired vaccine will be removed from the vaccine storage unit immediately to prevent inadvertent use. A report of all expired or spoiled state- supplied vaccines will be submitted to the Adult Program prior to submitting a new vaccine request. Affected vaccines will be returned to the program's vaccine distributor for excise tax credit within 6 months of expiration/spoilage.
9. **Monitor Vaccine Storage Unit Capacity to Store Vaccines - especially during flu season**
The vaccine coordinator shall continuously monitor the capacity of the vaccine storage units to ensure adequate space for inventory, especially during flu season. Additional vaccine storage units must be purchased if the size of the current unit cannot accommodate the inventory in a manner consistent with DSHS requirements.
10. **Immediate Notification of the Adult Program for Storage and Handling Incidents or Vaccine Shipment Issues**
If the refrigerator or freezer units experience out of range temperatures, immediate action will be taken to prevent spoilage of the vaccine. This includes extended power outages and vaccine storage unit malfunctions. Depending on the situation, this may necessitate transporting the vaccines as outlined in the emergency plan. Vaccines exposed to out of range temperatures will be marked "Do Not Use" until direction is received from the Adult Program. Contact the Adult Program immediately when out of range temperatures are identified. Shipment issues will be reported to the Adult Program within 2 hours of receiving the shipment.
11. **Order and Account for all State-supplied Vaccines in Accordance with Practice's Patient Profile and DSHS Guidelines**
Vaccines will be ordered in accordance with practice-based patient profile data, assigned Tiered Ordering Frequency (TOF), vaccine usage, and inventory on hand at the time of order placement. Practice will order all vaccines at one time. An accurate report of each state-supplied vaccine dose administered within each ordering period will be maintained. A summary of vaccine administration and on-hand inventory will be submitted with each vaccine request. All state-supplied vaccine doses will be accounted for.
12. **Receive and Unpack Vaccine Shipments Immediately Upon Arrival**
Vaccine shipments will not be rejected. All staff who may accept packages for the clinic must be aware that vaccine shipments require immediate attention. When new shipments arrive, vaccines should be unpacked immediately. Immediately upon receipt, vaccine shipments will be inspected to verify the shipping dates are within delivery range and that the vaccines included in the shipment match those listed on the invoice. Any shipment discrepancies or issues must be reported to the Adult Program within 2 hours of shipment delivery. Any change in the practice availability to receive vaccine shipments will be immediately reported to the Adult Program. Practice will assume responsibility for all state-supplied vaccine shipped to the site.

To receive state-supplied vaccines, you must confirm acknowledgement of this agreement.

Provider-in-charge: _____
(Print) First Name Last Name MI Title (M.D., D.O., N.P., R.Ph., P.A. or C.N.M.†)

Provider-in-charge: _____
(Signature) Date

† A licensed Medical Doctor, Doctor of Osteopathy, Nurse Practitioner, Registered Pharmacist, Physician Assistant or a Certified Nurse Midwife must sign the Enrollment Form.