New Jersey Department of Health
Vaccines for Children (NJVFC) Program
P.O. Box 369
Trenton, NJ 08625-0369
Phone: (609) 826-4862 Fax: (609) 826-4868

NEW PROVIDER ENROLLMENT FOR ADULT SITE

INSTRUCTIONS: *Email completed New Provider Enrollment for Adult Site and New Provider Agreement for Adult Site to: VFC@doh.nj.gov.*

Today's Date *(MM/DD/YYYY)*
__ __ / __ __ / __ __ __ __

PROVIDER INFORMATION

Office Name:

Office Medicaid Number: | Office NPI Number: | Office Tax ID:

Provider Type:

Private Facilities: ☐ Not for Profit Clinic *(Proof of not for profit status must be sent with this enrollment.)*

Public Facilities: ☐ Public Health Department ☐ Federally Qualified Health Center

Vaccines Offered *(Select only one box)***:**

☐ All ACIP Recommended Vaccines for Adults

☐ Offers Select Vaccines ***(This option is only available for facilities designated as "Specialty Providers" by the 317 Program.)***

A "Specialty Provider" is defined as a provider that only serves (1) a defined population due to the practice specialty (e.g., OB/GYN, STD clinic, family planning) or (2) a specific age group within the general population of adults ages 19+. Local health departments are not considered specialty providers. The 317 Program has the authority to designate 317 providers as specialty providers.

Select Vaccines Offered by Specialty Provider:

☐ Hepatitis A/B	☐ Meningococcal Conjugate	☐ TD
☐ HPV	☐ MMR	☐ Tdap
☐ Influenza	☐ Pneumococcal Conjugate	☐ Varicella
☐ Men B	☐ Pneumococcal Polysaccharide	☐ Zoster

☐ Other *(specify)*:

Vaccine Delivery Address

Address 1: | Address 2:

City: | State: NJ | Zip:

County: | Municipality:

Phone: ( ) | Ext. | Fax: ( )

Email:

LICENSED MEDICAL PROVIDERS

The Medical Director signing this agreement must be authorized to administer adult vaccines under state law. The Medical Director will be held accountable for 317-Funded Adult Program compliance by the entire organization with all items stated in the Provider Agreement for adult sites.

1. Medical Director | Title: ☐ MD ☐ DO | Date of Birth:

Last Name: | First Name: | Middle Name:

NPI No.: | Medical License No.: | Medicaid No.:

2. Licensed Medical Provider | Title: ☐ MD ☐ DO ☐ PA ☐ NP | Date of Birth:

Last Name: | First Name: | Middle Name:

NPI No.: | Medical License No.: | Medicaid No.:

NEW PROVIDER ENROLLMENT FOR ADULT SITE
(Continued)

LICENSED MEDICAL PROVIDERS, CONTINUED

3. Licensed Medical Provider Title: ☐ MD ☐ DO ☐ PA ☐ NP Date of Birth:

Last Name: First Name: Middle Name:

NPI No.: Medical License No.: Medicaid No.:

4. Licensed Medical Provider Title: ☐ MD ☐ DO ☐ PA ☐ NP Date of Birth:

Last Name: First Name: Middle Name:

NPI No.: Medical License No.: Medicaid No.:

ASSOCIATED ADDITIONAL MEDICAL OFFICES

(Complete this section only if there are other offices in the practice. If none, go to next section.)

1. Medical Office Name: VFC Pin:

Street 1: Street 2:

City: State: NJ Zip:

County: Municipality:

Phone: ( ) Ext. Fax: ( )

2. Medical Office Name: VFC Pin:

Street 1: Street 2:

City: State: NJ Zip:

County: Municipality:

Phone: ( ) Ext. Fax: ( )

ADULT SITE CONTACTS

Two designated on-site and fully trained staff responsible for all vaccine management activities within the practice.

Primary Vaccine Coordinator:

Last Name: First Name: Middle Name:

Email: Phone: Ext.

Backup Vaccine Coordinator:

Last Name: First Name: Middle Name:

Email: Phone: Ext.

VACCINE DELIVERY HOURS
(Hours when vaccine shipments can be delivered. Exclude lunch hours if office is closed. Note: No deliveries are made on Mondays.)

☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

From (hh:mm): ____ : ____ To (hh:mm): ____ : ____ AND

From (hh:mm): ____ : ____ To (hh:mm): ____ : ____

☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

From (hh:mm): ____ : ____ To (hh:mm): ____ : ____ AND

From (hh:mm): ____ : ____ To (hh:mm): ____ : ____

☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

From (hh:mm): ____ : ____ To (hh:mm): ____ : ____ AND

From (hh:mm): ____ : ____ To (hh:mm): ____ : ____

Special Delivery Instructions: ____

NATIONAL INSTITUTE OF STANDARDS AND TECHNOLOGY (NIST) THERMOMETERS
(Enter only one Certification Number for dual probe thermometer Certificates.)

Thermometers:

1. Type:	☐ Data Logger ☐ Digital Min/Max Thermometer	Certification or Serial Number:		NIST Certification Expiration Date:	
2. Type:	☐ Data Logger ☐ Digital Min/Max Thermometer	Certification or Serial Number:		NIST Certification Expiration Date:	
3. Type:	☐ Data Logger ☐ Digital Min/Max Thermometer	Certification or Serial Number:		NIST Certification Expiration Date:	
4. Type:	☐ Data Logger ☐ Digital Min/Max Thermometer	Certification or Serial Number:		NIST Certification Expiration Date:	

Back-Up Thermometer *(Required)*:

1. Type:	☐ Data Logger ☐ Digital Min/Max Thermometer	Certification or Serial Number:		NIST Certification Expiration Date:	

NEW PROVIDER ENROLLMENT FOR ADULT SITE
(Continued)

PROVIDER POPULATION:

Provider population based on patients seen during the previous 12 months. Report the number of adults who received vaccinations at your facility, by age group. Only count an adult once based on the status at the last immunization visit, regardless of the number of visits made. The following table documents how many adults received 317-funded vaccine, by category, and how many received non-317 vaccine.

	Number of Adults Who Received Vaccine by Age Category			
317 Vaccine Eligibility Categories	**19-29 years old**	**30-39 years old**	**40-59 years old**	**60+ years old**
• No Health Insurance				
• Underinsured [1]				
Non-317 Vaccine Eligibility Category	**19-29 years old**	**30-39 years old**	**40-59 years old**	**60+ years old**
• Health Insurance Pays Some/All Vaccine Cost				

[1] *Underinsured includes adults with health insurance that does not include vaccines or only covers specific vaccine types. Adults are only eligible for vaccines that are not covered by insurance.*

TYPE OF DATA USED TO DETERMINE PROVIDER POPULATION *(Choose ALL that apply):*

☐ Benchmarking ☐ Doses Administered
☐ Medicaid Claims Data ☐ Provider Encounter Data
☐ NJIIS ☐ Billing System
☐ Other *(must describe)*:

The Medical Director signing this agreement must be authorized to administer adult vaccines under state law. The Medical Director will be held accountable for 317-Funded Adult Program compliance by the entire organization with all items stated in the Provider Agreement for adult sites.

Print Name of Medical Director: | Signature of Medical Director: | Date:

FOR STATE USE ONLY											
Date Certified for NJVFC			Staff Name			PIN Number					
Federal HHS OIG Search Done	☐ Yes ☐ No		NJ Consumer Affairs OIG Search Done	☐ Yes ☐ No		Address Checked on USPS Site	☐ Yes ☐ No		Correction made to conform to USPS Address	☐ Yes ☐ No	Checked Not for Profit Status ☐ Yes ☐ No
Document clarification of HHS OIG an NJ Division of Consumer Affairs issues here:											