Chicago Department of Public Health
Immunization Program

Vaccines for Adults (VFA) Project Application

Background and Purpose
In the U.S., more than 42,000 adults die each year from vaccine-preventable diseases. The licensure of new vaccines (e.g., Tdap, HPV, herpes zoster) and the optimal use of older vaccines (e.g., influenza, pneumococcal, hepatitis B) have a great potential to protect and improve the health of adults. Although many adults have private medical insurance, there is currently no comprehensive program to finance vaccines for those who are uninsured or underinsured or to create infrastructure to support the vaccination of these individuals.

The Chicago Department of Public Health Immunization Program (CDPH) is seeking applications from Federally Qualified Health Centers (FQHCs) to provide free or low cost immunizations to uninsured and underinsured adults (19 years and older).

Select adult vaccines will be available for distribution to successful applicants beginning October 1, 2014 and ending September 30, 2017. The exact amount of vaccine may fluctuate from year to year resulting in variation of available funding over the three year period.

Limitations
- No operating funds are available and vaccines must be ordered through the Chicago Department of Public Health.
- No redistribution of vaccine will be allowed.
- There are limitations on which vaccines will be available:
  - Only vaccines that are available on the federal adult contract

Eligibility Requirements
Eligible Federally Qualified Health Centers (FQHCs) are those with at least one year experience in routinely providing free or low cost immunization services and act as a safety net for uninsured and underinsured adults.

Submission Deadline
Applications are due no later than Friday, August 22, 2014 at 4 PM, Central Time. Failure to meet the required deadline, or submission of an incomplete application, will result in the application being eliminated from consideration. Faxes will not be accepted. All applications must be emailed to maribel.chavez-torres@cityofchicago.org
Application Process
Complete a cover letter and include the following attachments:

1. Organization Description (2 page maximum) which includes the following:
   - Number of years providing adult immunizations
   - Experience with adult immunization community outreach
   - The percentage of uninsured and underinsured patients in current program
   - Geographic location of FQHC and population(s) served
     - Geographic location may be taken into account to ensure availability of adult vaccine in all regions of the city.

2. Project description (3 page maximum) which includes the following:
   - Past participation in the Chicago VFC program (when applicable).
   - Planned mechanism for tracking adult vaccines administered.
   - Description of planned vaccine reminder/recall efforts.
   - Special consideration will be given to organizations that will be increasing the number of adults and/or the types of vaccines provided.

3. Promotional/Marketing Plans (2 page maximum)
Community outreach efforts: How will the community know about the adult program (e.g. radio advertisements, newspaper ads, pamphlets, etc.). Please describe specifically how your organization is planning to publicize the availability of free immunizations for uninsured and underinsured adults (19 years and older). Please indicate all relevant activities and provide a brief description of your agencies plans.

- [ ] Offer vaccine to adults coming in for other reasons. Specific plans:

- [ ] Advertise in local community newspapers, radio stations, or TV stations. Specific plans:

- [ ] Distribute a brochure. Specific plans:

- [ ] Display a poster. Specific plans:

- [ ] Other strategy. Specific plans:

4. Program Requirements
Attached is the 2014 Provider Agreement that outlines the Adult for Vaccines (VFC) program requirements. For information on vaccine storage and handling, please visit [http://www.cdc.gov/vaccines/ed/youcalltheshots.htm](http://www.cdc.gov/vaccines/ed/youcalltheshots.htm).

Of particular importance are the following:
- Have appropriate vaccine storage units
- Use calibrated NIST thermometers to monitor temperatures
- Manually check and record temperatures twice a day
Chicago Department of Public Health
Immunization Program

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- Develop a process for screening for eligibility at each immunization visit
- Charge no more than $23.87 for an administration fee
- Submit an annual vaccine project plan
- Submit required reporting elements (as per CDPH timelines)
  - Doses on hand
  - Doses administered by age group (19-24, 25-44, 45-64, 65+)
  - Total number of doses administered by vaccine type

5. Copy of the HRSA FQHC determination letter.

Format Instructions
- Submit application documents in the order listed on the cover letter form
- Use at least 1.5 line spacing, Times New Roman 11-point font size, on 8 ½” x 11” paper
- Applications should have margins of at least ¾ inch on all sides
- Attach only supporting documentation requested or directly related to the application
- Sequentially number the entire application including all the attachments
- All applications and supporting materials must be submitted to maribel.chavez-torres@cityofchicago.org

Evaluation of Applications
All applications will undergo a technical review to determine whether all required components have been addressed and included. Incomplete or late applications will not be considered. Funding is contingent on the availability of vaccine funds. The City reserves the right to waive irregularities that, within its sole discretion the City determines to be minor. If such irregularities are waived, similar irregularities in all applications will be waived. A Review Panel will evaluate, rate, and approve all applications.

For questions related to the application process please contact Maribel Chavez-Torres at 312-746-6120.
Chicago Department of Public Health
Immunization Program

Vaccines for Adults (VFA) Project Application

Cover Letter

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<tr>
<th><strong>Organization Name and Mailing Address:</strong></th>
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<tr>
<th><strong>Executive Director:</strong></th>
<th><strong>Executive Director’s phone number and email address:</strong></th>
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<th><strong>Medical Director’s Name:</strong></th>
<th><strong>Medical Director’s phone number and email address:</strong></th>
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<tr>
<th><strong>Primary Contact Person:</strong></th>
<th><strong>Primary Contact’s phone number and email address:</strong></th>
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**Application Checklist:**
- Complete Cover Letter form (this page)
- Organization Description (2 page maximum)
- Project (3 pages maximum)
- Marketing plans (2 page maximum)
- FQHC Determination Letter

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<thead>
<tr>
<th><strong>Signature of the Executive Director:</strong></th>
<th><strong>Date:</strong></th>
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# FACILITY INFORMATION

<table>
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<th>Facility Name:</th>
<th>Pin#:</th>
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<tr>
<td>Facility Address:</td>
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<td>City:</td>
<td>Zipcode:</td>
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<tr>
<td>Telephone:</td>
<td>Fax:</td>
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<tr>
<td>Shipping Address (if different than facility address):</td>
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<tr>
<td>City:</td>
<td>Zipcode:</td>
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<td>State:</td>
<td>Zip:</td>
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# MEDICAL DIRECTOR OR EQUIVALENT

**Instructions:** The official registered health care provider signing the agreement must be a practitioner authorized to administer adult 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.

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<thead>
<tr>
<th>Last Name, First, MI:</th>
<th>Title:</th>
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<tr>
<td>Specialty:</td>
<td>Medicaid/License No:</td>
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<tr>
<td>Employer Identification Number:</td>
<td>NPI No:</td>
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# VACCINE COORDINATOR

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<thead>
<tr>
<th>Primary Vaccine Coordinator Name:</th>
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<tr>
<td>Telephone:</td>
<td>Email:</td>
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<tr>
<td>Back-Up Vaccine Coordinator Name:</td>
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<td>Telephone:</td>
<td>Email:</td>
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**PROVIDERS PRACTICING AT THIS FACILITY** *(additional spaces for providers at end of form)*

**Instructions:** List below all licensed health care providers (MD, DO, NP, PA, pharmacist) at your facility who have prescribing authority.

<table>
<thead>
<tr>
<th>Provider Name</th>
<th>Title</th>
<th>Medicaid/ License No.</th>
<th>NPI No.</th>
<th>EIN (Optional)</th>
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# PROVIDER AGREEMENT

To receive publicly funded 317 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 practice administrator or equivalent:

1. 317 vaccine can only be administered to uninsured or underinsured adults aged 19 years and older. “Underinsured” adults are individuals who are covered by health insurance, but the coverage does not include vaccines; the insurance covers only selected vaccines; or the insurance caps vaccine coverage at a certain amount. Once that coverage amount is reached, the individual is categorized as underinsured. Verification of whether an individual is underinsured can be obtained verbally from the individual.

2. Comply with the most recent immunization schedule, dosage, and contraindications established by the Advisory Committee on Immunization Practices (ACIP) unless: a) in making a medical judgment in accordance with accepted medical practice, I deem such compliance to be medically inappropriate or b) the patient declines particular immunizations.

3. Not charge for the cost of the 317-funded vaccine.

4. Not charge a vaccine administration fee to 317-funded eligible patients that exceed the administration fee cap of $23.87 per vaccine dose.

5. Not deny administration of any vaccine received from the Vaccines for Adult (VFA) program to a patient due to the inability of an individual to pay the administration fee.

6. 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).

7. I will comply with the requirements for vaccine management including:
   a) Vaccine ordering 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 State/Local/Territorial Immunization Program storage and handling recommendations and requirements;
   d) Returning all spoiled/expired public vaccines to CDC’s centralized vaccine distributor within six (6) months of spoilage/expiration.

8. Retain the patient’s written responses about 317-funded eligibility status and all records related to the 317 Vaccine program for a period of three (3) years. If requested, I will make the records available to CDPH. Release of such records will be bound by applicable federal and state privacy laws.

9. Agree to operate within the 317 Vaccine Program guidelines intended to avoid fraud and abuse.

10. Permit visits to my facility by authorized representatives of the 317 Vaccine Program to review compliance with VFA policies and procedures. Release of such records will be bound by all federal and state privacy laws.

11. Understand that this facility or the Chicago Immunization Program may terminate this agreement at any time for personal reasons, no reason, or failure to comply with these requirements upon five (5) days’ prior written notice to the other party. If I choose to terminate this agreement, I will properly return any unused 317-funded vaccine.

12. The term of this Agreement is from **October 1, 2014 – September 30, 2014** unless terminated earlier. If I want to participate in the VFA Program after this Agreement expires, then I will be required to re-apply for enrollment annually by completing a new Practice Profile Form and Provider Agreement. Re-enrollment is not guaranteed and may be denied for any reason. Failure to re-apply for enrollment will mean suspension and possible termination from the VFA program. I will comply with City’s Vaccine Loss and Replacement Policy, Fraud and Abuse Policy 317 Purchased Vaccines.
By signing this form, I certify on behalf of myself and all immunization providers in this facility, I have read and agree to the Adult Vaccines for Adult (VFA) enrollment requirements listed above and understand I am accountable (and each listed provider is individually accountable) for compliance with these requirements.

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<tr>
<th>Medical Director or Equivalent Name (print):</th>
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| Signature:                                  | Date:  