

# How to Enroll with New York State Department of Health (NYSDOH) COVID-19 Vaccination Program

11/13/20

## Background

New York State healthcare organizations (with locations outside of New York City) interested in administering COVID-19 vaccine must enroll in the NYSDOH COVID-19 Vaccination Program to be ready to order and receive publicly supplied COVID-19 vaccine and ancillary supplies. The enrollment process is completed through the Health Commerce System (HCS) online application tool named COVID-19 Vaccine Program Provider Enrollment. The online tool contains the Provider Agreement and Profile sections outlined below. The sections in the tool mirror the CDC COVID-19 Vaccination Program Provider Agreement and include an addendum with NYSDOH questions. This **Enrollment Instructions Guide** provides a detailed explanation and important information about completing the application fields.

**Note: Only vaccination provider locations outside the five boroughs of New York City (NYC) may enroll with NYSDOH.** Providers located within NYC must seek guidance from the New York City Department of Health and Mental Hygiene (NYCDOHMH) regarding enrollment.

There are TWO sections to the enrollment:

### Section A: COVID-19 Vaccination Program Provider Requirements and Legal Agreement

This section specifies the conditions of participation for vaccination provider organizations and their constituent facilities in the federal COVID-19 vaccination program. The medical (or equivalent role) and chief executive officer (or chief fiduciary) signing this agreement must be the individuals who will be held accountable for and responsible for compliance with the conditions outlined in the agreement. (Note: In the online tool signatures are obtained using an attestation check box.)

### Section B: CDC COVID-19 Vaccination Program Provider Profile and Addendum

This section outlines key minimum data elements required by CDC to be collected from every \*vaccination provider location receiving COVID-19 vaccine and constituent products, such as receiving site address information, practice type, and patient population size and volume. An addendum includes questions required by NYSDOH.

\*Only provider locations that will receive (through shipments) and administer vaccine should be included in Section B. **Do not** include point-of-dispensing sites (i.e. sites where an enrolled vaccination provider will bring vaccine for administering to a targeted population on the same day).

A vaccination provider parent organization with multiple facility locations may enroll those facility locations by either:

1. Completing Section A and adding each facility that will receive and administer vaccine under one application by completing a Section B for each; or
2. Having each facility location enroll independently by completing a Section A and Section B.

## Step by Step Guide to completing the enrollment fields in the online system

**Important:** Remember to periodically click on the save icon in the lower right corner of the screen while working on the application.



### **SECTION A: COVID-19 Vaccination Program Provider Requirements and Legal Agreement**

1. **Organization Identification:** This section should be filled in with the provider organization information (i.e. health system, medical group, parent organization).

Question	Description/Important Info
Organization's legal name	Legal name of the organization
Number of affiliated vaccination locations covered by this agreement	This is the number of Section B vaccination provider locations submitted with the agreement. When completing on the Health Commerce System (HCS) this will auto-populate based on number of Section B Profiles submitted.
Organization telephone	Contact phone for the main organization
Email	Will serve as dedicated contact method for COVID-19 Vaccination Program. If submitting on HCS this email will receive the confirmation of submission and PDF copy of the completed application.
Street address/ City/County/State/Zip	Address of main organization

2. **Responsible Officers:** These individuals are accountable for compliance with the conditions specified in the agreement.

Question	Description/Important Info
Chief Medical Officer (or Equivalent)	Must hold a medical license. Equivalent may include roles such as Public Health Director or Director of Nursing.
Chief Executive Officer or Chief Fiduciary (or Equivalent)	If your organization does not have a CEO, the CMO can be listed in both places.

Note: In HCS the signatures are obtained through an attestation by typing the name where indicated and checking an attestation box. This is the equivalent of a handwritten signature. The typed name must be the CMO and CEO/CFO listed in the application.

### **SECTION B: CDC COVID-19 Vaccination Program Provider Profile Form**

All locations listed in this section must adhere to all requirements outlined in Section A, including having capacity to store and monitor vaccine and a prescribing provider and medical staff to administer vaccine. In the online tool, each time you enter complete information for a location, you will have the option to click a button to add information for another location.

3. **Organization identification for individual locations**

Question	Description/Important Info
Organization location name	Name of this vaccination location (i.e. Practice name)
Will another Organization location order COVID-19 vaccine for this site	If you anticipate needing to receive vaccine from another provider due to minimum order quantity (at least 100 doses) please indicate YES.
If YES, provider Organization name	If you answer YES, provide the name of the organization location you anticipate ordering vaccine for this location.

4. **Contact information for location’s primary COVID-19 vaccine coordinator:** The primary vaccine coordinator is the person located **on-site** at the vaccination location that has overall responsibility for the vaccine including receiving shipments, monitoring storage unit temperatures, and managing inventory. If enrolling multiple sites, there should be different vaccine coordinators (do not list the same vaccine coordinator on each Section B).
5. **Contact information for location’s backup COVID-19 vaccine coordinator:** The backup vaccine coordinator will serve as the vaccine coordinator when the primary coordinator is not available. This individual should be on-site when primary coordinator is not available.
6. **Organization location address for receipt of COVID-19 vaccine shipments:** This is the address where deliveries would be made to **this location**. We must have the shipping address for the vaccination provider location, so they have the ability to order and receive direct shipments. PO Boxes are not allowed. Do not list another vaccination provider address even if you anticipate another provider receiving vaccine and redistributing to this location.

**Only addresses in the 57 counties outside of NYC are allowed. If the location is within the five boroughs of NYC enrollment must be done through the NYCDOHMH.**

7. **Organization address of location where COVID-19 will be administered:** This is the vaccination provider’s address. It will almost always be the same as the shipping address above. An example where they may differ is if shipments are received at a loading dock and the provider’s office is in another suite.

**Only addresses in the 57 counties outside of NYC are allowed. If the location is within the five boroughs of NYC enrollment must be done through the NYCDOHMH.**

8. **Days and times vaccine coordinators are available for receipt of COVID-19 vaccine shipments:** List all hours Monday through Friday that shipments may be received. At least one day must have hours to receive shipments.
  - In the fillable PDF the input format is ‘HH:MM-HH:MM’ (i.e. 08:30-04:30)
  - In the HCS you may choose any hour/minute and am/pm for time open and time closed each day.

9. **COVID-19 vaccination provider type for this location (select one):** Please choose the provider type that best fits this vaccination provider location. Please carefully review and select from the choices listed in the provider type. In the rare event you cannot find your provider type, you may choose “other” and specify your provider type in the box. Only one selection is allowed.
10. **Setting(s) where this location will administer COVID-19 vaccine (select all that apply):** Choose all settings this vaccination provider location will administer vaccine. If you choose “Other”, you must specify the other setting not listed. Multiple selections are allowed.
11. **Approximate number of patients/clients routinely served by this location:** This question is used to understand the population you routinely serve that may be targeted for vaccination. It is specific to patients/clients (including residents for LTCFs or individuals receiving services in other congregate settings). **Do not report employees/staff in this area.**

Question	Description/Important Info
Number of children 18 years of age and younger	Estimated non-duplicated patient population over the last 12 months in each age group. For each age group you must enter a number or check ‘Unknown.’ If you routinely serve patients, please try to enter a number rather than selecting ‘Unknown.’ If you are a non-traditional provider that does not have a routine patient population, you may enter 0.
Number of adults 19-64 years of age	
Number of adults 65 years of age and older	
Number of unique patients/clients seen per week on average	This is the average non-duplicated number of patients/clients seen/served weekly. If you are a commercial vaccination provider (such as pharmacy, essential worker employee health services) you may choose ‘Not applicable.’ Must enter a number, check ‘Unknown’ or check ‘Not applicable’

12. **Influenza vaccination capacity for this location:**

Question	Description/Important Info
Number of influenza vaccine doses administered during the peak week of the 2019-2020 influenza season	The peak week is not a defined week of the year, but rather the week in which the most flu vaccines were administered by this vaccination provider location. This number may include vaccines administered to employees if that was the peak week.

13. **Population(s) served by this location (select all that apply):** Choose all applicable populations this vaccination provider location will serve. If you choose Other people at

higher risk for COVID-19, you must specify the other population not listed. Multiple selections are allowed.

14. **Does your organization currently report vaccine administration data to the state, local, or territorial immunization information system (IIS)?** All enrolled providers must use the New York State Immunization Information System (NYSIIS) for ordering vaccine and reporting vaccine administration.

Question	Description/Important Info
If Yes, List IIS Identifier	If this vaccination provider location already has a NYSIIS account, please provide the NYSIIS Org ID. See attached instructions on how to find a NYSIIS Org ID. Note: Every vaccination provider location must have their own NYSIIS Org ID for reporting; NYSIIS Org IDs cannot be shared
If NOT, please explain planned method for reporting vaccine administration data to the jurisdiction's IIS or other designated system as required	If you do not currently have a NYSIIS Organization, one will be set up for you when completing the enrollment. NYSIIS staff will work with vaccination provider locations to get users access and set up data exchange, if necessary. If you already have a NYSIIS Org ID for data exchange that you want the new Org linked to, you may note that in this area. (NOTE: data exchange is not required but is a method some providers use to send data from their EHR).
If NOT APPLICABLE, please explain	All Organizations will be required to use NYSIIS for ordering, so this option should not be used for a response.

15. **Estimated number of 10-dose multidose vials (MDVs) your location is able to store during peak vaccination periods (e.g. during back-to-school or influenza season) at the following temperatures:** This is the capacity at this vaccination provider location to store vaccine at the temperatures listed. Each vaccination provider location **MUST have storage capacity on-site for at least one of the temperature ranges** listed to be eligible to enroll. Do not list capacity of an ordering provider if you are requesting redistribution.

Capacity at each temperature will be used to determine which vaccine product your vaccination provider location may receive. The units must be monitored to ensure consistent temperatures within the defined range can be maintained. Household combination units are discouraged but may be used if temperatures have been monitored and shown to maintain appropriate temperatures.

Question	Description/Important Info
Refrigerated (2°C to 8°C)	For each of the temperature ranges listed, you must indicate either 'No Capacity' or fill in the approximate capacity in <b>10-dose MDVs</b> . Be careful to convert total dose capacity to quantity of 10-dose MDVs.

Frozen (-15°C to -25°C)	<p>If you have more than one unit at a temperature you may add together total capacity for all units that may store COVID-19 vaccine at that temperature. If you have a unit but it is already at full capacity and cannot take additional products, do not include it in capacity.</p> <p>NOTE: Ultra-frozen units are not common. This is a special pharmaceutical grade unit.</p> <p>NOTE: Do not list capacity for any units you have purchased but not yet received. If you purchase a unit and receive it after your application is submitted, you may notify the COVID-19 Vaccine Program of the update.</p>
Ultra-frozen (-60°C to -80°C)	

16. **Storage unit details for this location:** List the brand/model/type of storage units to be used for storing COVID-19 vaccine at this location. You should list each unit that was used in the prior question to determine capacity. Please include the following in the details.

- Type of unity: Refrigerator, Freezer, or Ultra-Cold Freezer
- Make/model: description of the unit
- Grade of unit: Household/commercial stand alone, Household/commercial combination, or Pharmaceutical

17. **Location Attestation:** Each vaccination provider location must attest that each unit listed will maintain appropriate temperature range. This must be signed by the medical/pharmacy director or the location’s vaccine coordinator.

18. **Providers practicing at this facility:** List all licensed healthcare providers at this location who have prescribing authority. For large facilities, only list the providers that will prescribe or issue a standing order for COVID-19 vaccination. A subset of no more than 25 providers with this authority is recommended. Healthcare providers must be licensed in New York State. In the Title, please list the specific license type issued by the New York State Department of Education, Office of the Professions. Allowable professions include:

<ul style="list-style-type: none"> <li>• Medicine</li> <li>• Medicine, limited license</li> <li>• Pharmacist</li> <li>• Pharmacist, limited license</li> <li>• Registered Physician Assistant</li> <li>• Nurse Practitioner, Adult Health</li> <li>• Nurse Practitioner, College Health</li> <li>• Nurse Practitioner, Community Health</li> <li>• Nurse Practitioner, Family Health</li> <li>• Nurse Practitioner, Gerontology</li> <li>• Nurse Practitioner, Neonatology</li> <li>• Nurse Practitioner, Obstetrics &amp; Gynecology</li> </ul>	<ul style="list-style-type: none"> <li>• Nurse Practitioner, Oncology</li> <li>• Nurse Practitioner, Pediatrics</li> <li>• Nurse Practitioner, Perinatology</li> <li>• Nurse Practitioner, Psychiatry</li> <li>• Nurse Practitioner, School Health</li> <li>• Nurse Practitioner, Women’s Health</li> <li>• Nurse Practitioner, Acute Care</li> <li>• Nurse Practitioner, Palliative Care</li> <li>• Nurse Practitioner, Holistic medicine</li> <li>• Nurse Practitioner, Anesthesia</li> </ul>
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## **ADDENDUM: NYS COVID-19 Vaccine Provider Profile Addendum**

Responses are required for every vaccination provider location.

19. **Is your facility willing to vaccinate individuals that are not established patients (walk-in clinics, mass vaccination clinics, employee clinics, etc.)?** If the vaccination provider location is willing to vaccinate individuals that are not established patients, including the provider's employees, answer YES to this question.

If you answer YES, fill in the table to estimate the number of individuals that are not established patients you may be able to vaccinate. If you have health care workers at your location, please categorize them into the age and risk groups listed. If you are not planning to target any of specific groups listed, include your estimates in the "Clinics for general population" category.

20. **Can your facility administer 1,000 doses of COVID-19 vaccine over the course of 10 days?** This question is used primarily to assess the vaccination provider location's ability to use a specific vaccine product that has ultra-cold storage requirements. The information may also be used more broadly to assess vaccine administration capacity regardless of product type.

21. **How many health care workers/personnel could your facility vaccinate within 10 days?** This question is used primarily to help identify early vaccination providers that may use the ultra-cold vaccine product to vaccinate health care workers in the first phase of vaccine availability. The information may also be used more broadly to assess vaccine administration capacity regardless of product type.

22. **Format of distribution (point-of-dispensing)?** This question is specific to the format of distribution for the number of health care workers you could vaccinate within 10 days.

A Closed POD is one where you plan to only vaccinate your own health care workers.

An Open POD is one where you will vaccinate your own health care workers as well as health care workers from other organizations.

### **Submitting your enrollment and downloading a PDF copy**

**Important:** Do NOT click the Submit button until you have entered and saved all information for all locations. Once you click Submit you will not be able to return to your form to make changes.

**To save your application, click on the icon on the bottom right of the application.**



After all information has been entered for all locations, you will be ready to click the Submit button. When you click the Submit button one of the following will occur:

- 1. Errors:** If the system detects errors in your submission, you will receive a message that error(s) must be corrected. These errors will appear in RED throughout the application. You will need to review and correct the errors, save the updated information and click Submit.
- 2. Submission Successful:** If no errors are found, you will receive a message that your COVID-19 Vaccine Program Provider Agreement and Profile has been submitted. The message will contain a **Reference ID** number. Please retain this number for communicating with the NYSDOH COVID-19 Vaccine Program regarding your enrollment.

### **Downloading a PDF of your submitted enrollment**

Before leaving the submission page, click the Download PDF button and save a copy of your submitted enrollment.

### **NYSDOH Review**

NYSDOH will review your submission. Please monitor your inbox for emails regarding enrollment status and next steps.