2018 Annual Recertification Process
Detailed Instructions for Completing Recertification in VOMS

The Annual Provider Recertification process must be completed for individual public and private facilities approved by the State for receipt of publicly vaccines through the Indiana Immunization Division. The Immunization Division maintains this record on file within the Indiana State Immunization Registry’s online ordering system, VOMS. The annual documentation must be updated annually or more frequently, if information changes. Each provider facility should designate one individual to complete the Recertification in VOMS. This is usually the Primary VFC Coordinator or the Practice Manager and he/she must have VOMS access.

Upon completion of the Annual Provider Recertification process in VOMS, providers must print off a copy of the Provider Agreement, obtain the appropriate signature and submit this along with the VFC Profile Report. These forms should be emailed (preferred method) or faxed to the Indiana Immunization Division using one of the following methods. Please include the VFC PIN # in the subject line for any email.

Fax – 317-972-8964 Email – immunize@isdh.in.gov vaccine@isdh.in.gov

Please contact the VOMS Helpdesk at 1-855-791-0393 if you have any questions.

› Login into CHIRP at https://chirp.in.gov
› Click the Provider Agreement button in the Navigation Menu

Note: When searching by First and Last Name, you may use the wildcard character % to replace multiple characters and _ to replace a single character.

Check here if adding a new patient

Add Anonymous Clear Search
2018 Annual Recertification Process
Detailed Instructions for Completing Recertification in VOMS

- Click on the Add button to open the new Recertification
  - This will add the 2018 Recertification Provider Agreement
  - If your site was enrolled during 2017, you will see previously submitted versions of the Provider Agreement. You will still have to hit the Add button to start a new one for 2018.

Provider Agreement Add/Edit

- Verify that the VFC PIN, IRMS and Facility Names are correct.
  - If this is incorrect for any reason, call the VOMS Helpdesk at 1-855-791-0393
- Add the name of the Agreement Signatory and the Signatory Title. This should be the Medical Director (MD) or Chief Medical Officer (CMO) at the VFC facility.
  - This information must match the information submitted as the Signatory under the Contact Details and the Authorized Providers Add/Edit sections.
  - The medical provider notated here must sign the Provider Agreement that will be printed and returned to the Immunization Division. Signatures must be original, no stamps. A faxed copy is sufficient for the Annual Recertification process.
- Choose the last Provider Recertification that was submitted to the Immunization Division. Providers will choose 2017.
2018 Annual Recertification Process
Detailed Instructions for Completing Recertification in VOMS

- **Address Section**

<table>
<thead>
<tr>
<th>Facility Address:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Street Address:</strong> 2 N. MERIDIAN</td>
</tr>
<tr>
<td>Street Address:</td>
</tr>
<tr>
<td><strong>City:</strong> INDIANAPOLIS</td>
</tr>
<tr>
<td><strong>State:</strong> INDIANA</td>
</tr>
<tr>
<td><strong>County:</strong> MARION</td>
</tr>
<tr>
<td><strong>Zip Code:</strong> 46204</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Vaccine Delivery Address:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Check if vaccine delivery address is the same as facility address:</td>
</tr>
<tr>
<td><strong>Street Address:</strong></td>
</tr>
<tr>
<td>Street Address:</td>
</tr>
<tr>
<td><strong>City:</strong></td>
</tr>
<tr>
<td><strong>State:</strong> --select--</td>
</tr>
<tr>
<td><strong>County:</strong> --select--</td>
</tr>
<tr>
<td><strong>Zip Code:</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mailing Address:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Check if mailing address is the same as facility address:</td>
</tr>
<tr>
<td><strong>Street Address:</strong></td>
</tr>
<tr>
<td>Street Address:</td>
</tr>
<tr>
<td><strong>City:</strong></td>
</tr>
<tr>
<td><strong>State:</strong> --select--</td>
</tr>
<tr>
<td><strong>County:</strong> --select--</td>
</tr>
<tr>
<td><strong>Zip Code:</strong></td>
</tr>
</tbody>
</table>

- Verify the Facility Address section - this should be prepopulated with the data previously submitted to the VFC Program.
  - If this is incorrect or incomplete, it can be corrected in this section.
- Verify the Shipping Address – this should be this should be prepopulated with the data previously submitted to the VFC Program.
  - If this is incorrect or incomplete, it can be corrected in this section.
  - If the address is missing but is the same as the Facility Address, the box can be checked and it will populate this address.
- Verify the Mailing Address – this should be this should be prepopulated with the data previously submitted to the VFC Program.
  - If this is incorrect or incomplete, it can be corrected in this section.
  - If the address is missing but is the same as the Facility Address, the box can be checked and it will populate this address.

<table>
<thead>
<tr>
<th>Vaccine Delivery Address:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Check if vaccine delivery address is the same as facility address:</td>
</tr>
<tr>
<td><strong>Street Address:</strong> 2 N. MERIDIAN</td>
</tr>
<tr>
<td>Street Address:</td>
</tr>
<tr>
<td><strong>City:</strong> INDIANAPOLIS</td>
</tr>
<tr>
<td><strong>State:</strong> INDIANA</td>
</tr>
<tr>
<td><strong>County:</strong> MARION</td>
</tr>
<tr>
<td><strong>Zip Code:</strong> 46204</td>
</tr>
</tbody>
</table>
Contact Details:

| Type 1: | Primary Vaccine Coordinator ▼ |
| Contact First Name 1, Middle Initial 1, and Last Name 1: | JILL KING |
| Phone Number 1: | (317)233-8480 |
| Fax Number 1: | (317)972-0111 |
| Email Address 1: | JIKING@ISDH.IN.GOV |
| Completed Annual Training 1: | Yes □ No □ |
| Type Of Training Received 1: | ▼ |

- Up to 4 contacts can be added to this section. It does not matter what order the contacts are added but it must include the following:
  - Signatory Contact Information
    - This information must match the Signatory information submitted in the Provider Add/Edit - Agreement Signatory and the Authorized Providers Add/Edit sections.
    - If possible, include an email address for the Signatory.
    - Annual Training is not required for the Signatory.
  - Primary and Back-up Coordinators Contact Information
    - Please ensure that the email address is verified for both individuals. This is vital as this is used throughout the year to communicate changes and updates to your site.
    - Both the Primary and Back-up Coordinator must have completed the annual training requirement
      - Indicate what type of training was completed
        - Compliance/Site Visit
        - On-site training with a Health Educator
        - Completion of “You Call the Shots” training online
        - Labor of Love Conference
2018 Annual Recertification Process
Detailed Instructions for Completing Recertification in VOMS

Vaccine Offered

- Privately purchased childhood vaccines
- All ACIP Recommended Vaccines
- Offers Selected Vaccines (This option is only available for facilities designated as Specialty Providers by the VFC Program)

A “Specialty Provider” is defined as a provider that only serves:
- A defined population due to practice specialty (e.g., OB/GYN, STD Clinic, family planning). Please specify:
- A specific age group within the general population of children ages 0-18. Please specify:

Local health departments and pediatricians are not considered specialty providers. The VFC Program has the authority to designate VFC providers as specialty providers. At the discretion of the VFC Program, enrolled providers such as pharmacies and mass vaccinators may offer only influenza vaccine.

Select Vaccines Offered by Specialty Provider:

- DTaP
- HIB
- HEP A
- HEP B
- IPV
- Influenza
- Meningococcal Conjugate
- MMR
- Polio
- Pneumococcal Conjugate
- Pneumococcal Polysaccharide
- Varicella
- TD
- Tdap
- Other:

- If your facility carries privately purchased stock (for non-VFC eligible children) check ‘Privately purchased childhood vaccines’. Please check the box above if you provide privately purchased vaccines.

- Indicate whether the VFC facility offers all ACIP Recommended vaccines or if the facility only offers ‘Selected Vaccines’.
  - If providers offer all ACIP Recommended vaccines, only fill in the appropriate button above.
  - The Specialty Provider section is only for a facility that has been designated as Specialty Provider by the VFC Program.
    - If so, the appropriate facility type and select the vaccines which are administered at the facility.
2018 Annual Recertification Process
Detailed Instructions for Completing Recertification in VOMS

- Shipping Information

<table>
<thead>
<tr>
<th>Shipping Information:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday: 02:00 - 12:00 - 13:00 - 17:00</td>
</tr>
<tr>
<td>Tuesday: 08:00 - 17:00 - --select-- - --select--</td>
</tr>
<tr>
<td>Wednesday: 08:00 - 12:00 - 13:00 - 17:00</td>
</tr>
<tr>
<td>Thursday: --select-- - --select-- - --select-- - --select--</td>
</tr>
<tr>
<td>Friday: 08:00 - 12:00 - --select-- - 17:00</td>
</tr>
</tbody>
</table>

- Indicate for each day of the week the times in which the practice is open and shipments may be delivered. **Use only 24-hour or military time notation to denote shipping times.** Please see the attached PDF if you need assistance with the 24 hour time conversion.
  - If the VFC facility has a lunch hour when vaccines cannot be accepted, make sure this is documented in addition to any days the facility is closed.
  - It is essential that the Immunization Division be aware of when the facility is and is not available to accept vaccine shipments.
  - This should be reviewed and updated, as needed, each time a vaccine order is submitted in VOMS to ensure the most up-to-date delivery times are available.
  - Vaccines are never delivered on Saturdays, Sundays and/or national Holidays.

- Facility Type

- Check only one type of facility. If you are unsure, indicate “Other” and the Deputy Director will evaluate and determine the facility type.
  - There is an option to make a note, if additional information needs to be shared.

- Complete the Provider Agreement and proceed to the 2nd page

- Once all information on the Provider Agreement is complete hit Save and Add Provider
2018 Annual Recertification Process
Detailed Instructions for Completing Recertification in VOMS

- **Authorized Providers Add/Edit**
  
<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Initial</th>
<th>Title</th>
<th>Specialty</th>
</tr>
</thead>
<tbody>
<tr>
<td>McCormick</td>
<td>David</td>
<td>E</td>
<td>MD</td>
<td>Pediatrics</td>
</tr>
</tbody>
</table>

- **Active with this Practice**
<table>
<thead>
<tr>
<th>Medical License Number</th>
<th>Medicaid Provider Number</th>
<th>NPI Number</th>
<th>Medical Director or Equivalent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
<td>123456789</td>
<td>1234567890</td>
</tr>
</tbody>
</table>

- **Add the name of the medical provider included as the Agreement Signatory in the Provider Agreement section. This section must include the Medical Director (MD) or Chief Medical Officer (CMO) at the VFC site. The Medical Director’s name must match that from the Provider Agreement Add/Edit and the Contact Details sections.**
  - **This section must match the information submitted as the signatory under the Provider Add/Edit - Agreement Signatory and under the Contact Details.**
  - This section must also include the following:
    - Medical License Number – must be 9 alphanumeric digits – if you are prompted to use 10 alphanumeric digits, add a zero (0) to the beginning of your medical license number
    - Medicaid Provider Number – must be 9 numbers
    - NPI Number – must be 10 numbers

- **Add additional authorized providers by clicking the Add New Provider button**

- **Verify CHIRP Users**
  
<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Medical License Number</th>
<th>Medicaid Provider Number</th>
<th>NPI Number</th>
<th>Medical Director or Equivalent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lil</td>
<td>King</td>
<td>123456789</td>
<td>1234567890</td>
<td>1234567890</td>
<td>Yes</td>
</tr>
</tbody>
</table>

- **Indicate if the CHIRP users listed are still current at your VFC facility.**
  - Mark Yes or No.
  - Those individuals that are no longer current at the facility should also be removed in CHIRP. A User Removal Form should be completed and submitted.
2018 Annual Recertification Process
Detailed Instructions for Completing Recertification in VOMS

- Complete the Authorized Providers section and Proceed to the 3rd Page
  
  Back  Save and Add Provider/Practice Profile

  - Once all information on the Authorized Provider section is complete hit Save and Add Provider/Practice Profile

- Provider/Practice Profile

  Provider/Practice Profile
  
  This section is critical in determining the number of doses necessary to vaccinate all eligible children at this facility. Accurately recording your population is the best way to ensure you receive the correct amount of vaccine. Each provider must provide the VFC Profile Report that has actual data from the registry to document the number of children vaccinated at the VFC facility for a 12 month period of time from November 1, 2016 - October 31, 2017. Print and save the report. The report will need to be submitted along with the Provider Agreement. It MUST be included with your recertification paperwork for your packet to be considered complete.

  Note:
  
  Click here to run the VFC profile Report

  - Providers must run the VFC Profile Report to document the number of children that have received VFC vaccines at the facility.
    - Click the link above to run the VFC Profile Report
    - If you click on this link a separate window opens, go ahead and run the report, hit print and then close of that window. This should return you to the Provider Agreement. Do not hit the back button or you may go back to the beginning.
    - You must enter a vaccine date range. The date range needs to be 12 months to equal a full year. We recommend you run your report from 11/01/16-10/31/17.
    - If you have access to more than one facility in CHIRP, you will also need to choose a facility from the drop down menu.

  - Once you see the report in your internet browser, please print and save the report. The report will need to be submitted along with the Provider Agreement. It MUST be included with your recertification paperwork for your packet to be considered complete.
    - If you feel the Profile Report is not accurate or if total number of children vaccinated is not available, please provide further justification with this data.

  - Indicate what data source used:

    2) What data source (or type of data) was used? (check all that apply)

    - [ ] Benchmarking
    - [ ] Medicaid Claims
    - [x] Doses Administered
    - [ ] Provider Encounter Data
    - [ ] Billing System
    - [ ] Other: _______
2018 Annual Recertification Process
Detailed Instructions for Completing Recertification in VOMS

- Complete the VFC Provider Profile and Proceed to Page 4

  - Once all information on the Provider/Practice Profile section is complete hit Save and Add Cold Storage Unit

- Cold Storage Unit

  - The storage units that store the publicly funded VFC vaccines must be documented in this section.

  - Verify that the VFC PIN and Clinic name are correct
  - Indicate if the VFC facility wants to be certified for frozen vaccine
    - Answer Yes or No
    - This section must be completed in order for a freezer to be added.

Instructions: Your refrigerator information is required for all units within your practice. Use the "Add" button to add additional units. If you choose to be certified for frozen vaccines, then you must answer the questions below and enter your freezer information.

- Freezer

  - Document if each freezer at the VFC facility maintains the appropriate temperature and if there is a separate, insulated door.
2018 Annual Recertification Process
Detailed Instructions for Completing Recertification in VOMS

- Proceed with documenting each freezer unit at this facility to include (add additional, as needed):
  - Storage Unit Name (required) – facility can provide name for this unit
  - Storage Unit Type (required) – choose one of the following:
    - Combination – freezer only
    - Combination – both freezer and fridge
    - Dorm-Style
    - Standalone – Commercial
    - Standalone – Pharmaceutical
    - Other
  - Manufacturer (required)
  - Model Number (required)
  - Effective Date – beginning date for when unit has been used/approved to store VFC vaccines
  - Purchase or Issue Date – optional, if unknown, leave blank

- Document the thermometer used in the above freezer
  - Thermometer Serial Number
  - Thermometer Type (required) – choose one of the following:
    - Continuous Monitoring Device (glycol) - (ex. Control Solutions, Smart Temps, Sonicu, SensoScientific, PharmaWatch, TempTrak)
    - Digital Data Logger (glycol) - (ex. FridgeTag, DeltaTrak, LogTag)
    - Other, indicate what type of device currently being used
  - Temperature Scale (required)
    - Celsius or Fahrenheit
  - Date of Last Calibration
  - Calibration Expiration (required)
Refrigerator

- Refrigerator
  - Refrigerator Name
  - Refrigerator Type
  - Manufacturer
  - Model Number
  - Effective From
  - Purchase or Issue Date
- Thermometer
  - Thermometer Serial Number
  - Thermometer Type
  - Temperature Scale
  - Date of Last Calibration
  - Calibration Expiration

- Proceed with documenting each refrigerator unit at this facility to include (add additional, as needed):
  - Storage Unit Name (required) – facility can provide name for this unit
  - Storage Unit Type (required) – choose one of the following:
    - Combination – fridge only
    - Combination – both freezer and fridge
    - Dorm-Style
    - Standalone – Commercial
    - Standalone – Pharmaceutical
    - Other
  - Manufacturer (required)
  - Model Number (required)
  - Effective Date – beginning date for when unit has been used/approved to store VFC vaccines
  - Purchase or Issue Date – optional, if unknown, leave blank
- Document the thermometer used in the above freezer
  - Thermometer Serial Number
  - Thermometer Type (required) – choose one of the following:
    - Continuous Monitoring Device (glycol) - (ex. Control Solutions, Smart Temps, Sonicu, SensoScientific, PharmaWatch, TempTrak)
    - Digital Data Logger (glycol) - (ex. FridgeTag, DeltaTrak, LogTag)
    - Other, indicate what type of device currently being used
  - Temperature Scale (required)
    - Celsius or Fahrenheit
  - Date of Last Calibration
  - Calibration Expiration (required)
2018 Annual Recertification Process
Detailed Instructions for Completing Recertification in VOMS

- **Final Check**
  - Here is a list of important data that you should review to ensure that all necessary information has been submitted to our program and will come over from VOMS accurately.
    - Include VFC Chief Medical Officer (CMO or Signatory) in all 3 locations in the Provider Agreement:
      1. Provider Agreement Add/Edit – Agreement Signatory (Section 1)
      2. Contact Details – Signatory
      3. Authorized Providers Add/Edit – Medical Director – you must mark that this Signatory or CMO is the Medical Director at the site in order for this information to carry over to the Provider Agreement page on the PDF.
2018 Annual Recertification Process
Detailed Instructions for Completing Recertification in VOMS

- Verify that the Primary and Back-up VFC Coordinator’s information is correct and the email address is spelled correctly. This is vital to allow for ongoing communication with your site.

- Ensure that you have answered the Cold Storage Unit question, “Do you want to be certified for frozen vaccine?”
  - If you have Varicella or MMRV in your inventory, you must answer this question as ‘Yes’ so that a freezer unit is added to your Provider Agreement.

- Certify and Submit to State

By checking and signing this document, I certify that facility/shipping/mailing addresses are accurate to ensure proper delivery. In addition, I certify that the appropriate storage is in place for the storage of all public vaccines.
2018 Annual Recertification Process
Detailed Instructions for Completing Recertification in VOMS

- Print PDF of Recertification and obtain necessary signature
  - Upon completion of the Annual Provider Recertification process in VOMS, providers must print off a copy of the Provider Agreement, obtain the appropriate signature and submit this along with the VFC Profile Report.
  - Read and sign the Provider Agreement – Please review all the terms of this agreement carefully. In order to participate in the Indiana Immunization Division Vaccines for Children (VFC) Program and receive publicly funded vaccines, the Medical Director (CMO) or equivalent must sign and abide by the conditions listed in the agreement, on behalf of themselves and all the practitioners, nurses and others associated with this medical office, group practice, Health Maintenance Organization, community/migrant/rural clinic health department or other entity of which the provider is the physician on record or equivalent.

Upon completion of the Annual Provider Recertification process in VOMS, providers must print off a copy of the Provider Agreement, obtain the appropriate signature and submit this along with the VFC Profile Report. These forms should be emailed (preferred method) or faxed to the Indiana Immunization Division using one of the following methods. Please include the VFC PIN # in the subject line for any email.

Fax – 317-972-8964  Email – immunize@isdh.in.gov or vaccine@isdh.in.gov

Please contact the VOMS Helpdesk at 1-855-791-0393 if you have any questions.