

# New York State COVID-19 Vaccination Program Provider Enrollment

# COVID-19 Vaccine Development

- Six vaccine manufacturers have received funding from the federal program “Operation Warp Speed” to produce a COVID-19 vaccine to be available in early 2021
  
- Four vaccines are in phase III trials in the U.S. to assess safety and whether the vaccine can prevent COVID-19
  - Moderna mRNA vaccine
  - Pfizer mRNA vaccine
  - Oxford/AstraZeneca DNA vaccine –trial paused
  - Johnson & Johnson/Janssen DNA vaccine – trial paused

# COVID-19 Vaccines Expected to Become Available First

## **Pfizer mRNA vaccine**

- Shipped at  $-70^{\circ}\text{C}$
- Can be stored in shipping container with replenishment of dry ice
- Can be stored at  $2-8^{\circ}\text{C}$  for up to 5 days
- 1000 dose order minimum
- 10 dose vials
- Requires reconstitution

## **Moderna mRNA vaccine**

- Shipped and stored at  $-20^{\circ}\text{C}$
- Can be stored at  $2-8^{\circ}\text{C}$  for up to 14 days
- Minimum 100 dose orders
- 5 dose vials
- No preservative or reconstitution needed

# COVID-19 Vaccine Assumptions

- Vaccine will only be available through CDC or NYSDOH initially
- Distribution will be limited by vaccine storage and handling requirements
- Two doses will be required
  - Interval is either 21 days (Pfizer) or 28 days (Moderna)
- Intramuscular administration
- Products will not be interchangeable
- Shipped with vaccination supplies

# COVID-19 Vaccine Availability

Expect vaccine to become available in two phases:

- I: Limited availability for highest priority groups
- II: Greater availability for general public

# COVID-19 Vaccine Availability Phase 1

- Limited supply for the country
  - Initially, 10-20 million doses by end of November
  - Another 10 million doses by end of December
- Vaccine would likely be available under an FDA Emergency Use Authorization and not be a licensed product
- CDC will likely distribute vaccine to
  - Federal locations (e.g., Veterans Health Administration sites)
  - Other national entities (e.g., chain pharmacies)
- Vaccine is likely to be offered at a smaller number of sites that can reach the target populations (e.g., hospitals and large medical facilities for administration to health care personnel)
- NYS allocation is not known

# COVID-19 Vaccine Availability Phase 2

- A licensed vaccine is expected as early as 2021
- This will mean greater availability to general public
- Production expected to start before vaccine is licensed
- NYSDOH would oversee vaccine distribution
- Broad distribution and availability
- Will expand on existing vaccination infrastructure to include providers such as independent health care providers, pharmacies, FQHCs, etc.

# COVID-19 Vaccine Distribution

- LHDs, medical facility networks, individual facilities, etc. and all administration sites will be required to complete a federal provider agreement and profile(s), available through the Health Commerce System.
- Vaccine will be ordered through the New York State Immunization Information System (NYSIIS).
- Orders will be reviewed and approved by NYSDOH Vaccine Program staff.
- Initially, shipments will likely be partial.
- Orders will be sent to CDC by NYSDOH using VTrckS, a CDC application
- Vaccine will be shipped directly to the facility from the vaccine manufacturer or CDC distributor.
- Reporting of all administered COVID vaccine doses is expected to be required.



# Are you ready?

- How will you allocate initial doses of vaccine?
- Consider those at higher risk of severe COVID-19 illness
- Are you set up in NYSIIS?
- Are you reporting adult vaccine doses in NYSIIS?

# CDC COVID-19 VACCINATION PROGRAM PROVIDER AGREEMENT

## **NYSDOH Enrollment in the Health Commerce System**

# How to access application on HCS

<https://commerce.health.state.ny.us/hcs/index.html>

A screenshot of the login form for the Health Commerce System. The form is enclosed in a rounded rectangle with a light gray border. It contains the following elements: a "User ID" label above a text input field; a "Password" label above a password input field; a link "Forgot Your User ID or Password" in blue; a checkbox labeled "Remember User ID"; a purple "LOGIN" button; and a link "Don't Have An Account? Sign Up Here" in blue at the bottom. Two yellow arrows point from the form to the explanatory text boxes on the right: one points to the input fields, and the other points to the "Sign Up Here" link.

Login to HCS using your User ID and Password

If you don't have an HCS account, click Sign Up Here link to fill out the account request form

# Add the COVID-19 Vaccine Enrollment Application

1. Go to My Content in the top menu bar and choose All Applications

The screenshot shows the top navigation bar of the Health Commerce System. The 'My Content' dropdown menu is open, and the 'All Applications' option is highlighted with a red box. The user is logged in as Lyndsey E Hoyt (leh02). The page also features a search bar, a 'My Applications' button, and several promotional banners for 'NYS DONATE LIFE REGISTRY', 'NYS PMP', and 'COVID Alert NY'. A 'D-19' banner is partially visible on the right side.

2. Click the letter C in the browse menu


Browse by **A** **B** **C** **D** **E** **F** **G** **H** **I** **J** **K** **L** **M** **N** **O** **P** **Q** **R** **S** **T** **U** **V** **W** **XYZ**


[View All](#)

# Add the COVID-19 Vaccine Enrollment Application

## 3. Scroll down until you see COVID-19 Vaccine Program Provider Enrollment

COVID-19 Contact Center Intake Form			Yes
COVID-19 Vaccine Program Provider Enrollment			
CR Facility Reporting Application			

Click the  in the column to the right to add to your My Applications menu on the HCS home screen for easy access next time you login. You will see a message at the top of the screen.

 The Application was successfully added your MyApps list

TIP: You may need to click Refresh My Applications List for it to appear

My Applications

Acronyms & Abbreviations	
CDMS	
CDMS v7	
COVID-19 Vaccine Enrollment	
Emergency Contacts	
HINAPCF	
Move development to test	
Move test to production	
ServNY	

**Refresh My Applications List**





## CDC COVID-19 Vaccination Program Provider Agreement

Please complete Sections A and B of this form as follows:

The Centers for Disease Control and Prevention (CDC) greatly appreciates your organization's (Organization) participation in the CDC COVID-19 Vaccination Program. Your Organization's chief medical officer (or equivalent) and chief executive officer (or chief fiduciary) —collectively, Responsible Officers —must complete and sign the CDC COVID-19 Vaccination Program Provider Requirements and Legal Agreement (Section A). CDC COVID-19 Vaccination Program Provider Profile Information (Section B) must be completed for each vaccination Location covered under the Organization listed in Section A.

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

#### ORGANIZATION IDENTIFICATION

Organization's legal name: \*

Required

Number of affiliated vaccination locations covered by this agreement: **1**

Organization telephone number: \*

(999) 999-9999? x99999

Email: \*

Required

(must be monitored and will serve as dedicated contact method for the COVID-19 Vaccination Program)

Address line 1: \*

Required

Address line 2:

Optional

# Two sections of the Enrollment

## Section A: Provider Requirements and Legal Agreement

- Specifies the conditions of participation and must be filled out for the **organization** (i.e. network, health system, or medical group)

## Section B: Program Provider Profile Form

- Must be filled out for **every** vaccination provider **location** receiving COVID-19 vaccine
- Collects info on address, practice type, patient population, storage capacity

If you are a group, you will submit a single Section A and multiple Section Bs *together*

If you are a single practice or clinic, you will have one Section A and one Section B

# Section A: Organization Identification

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

### ORGANIZATION IDENTIFICATION

Organization's legal name: \*

Required

Number of affiliated vaccination locations covered by this agreement: 1

Organization telephone number: \*

(999) 999-9999? x99999

Email: \*

Required

(must be monitored and will serve as dedicated contact method for the COVID-19 Vaccination Program)

Address line 1: \*

Required

Address line 2:

Optional

City: \*

Required

County \*

Select county

State: \*

Select state

ZIP code: \*

99999

This information will be filled out for the organization

The email address entered here is important as it will be the contact method to communicate enrollment determination and next steps



## Section A: Responsible Officers

The Chief Medical Officer (or Equivalent) and the Chief Executive Officer (or Chief Fiduciary) are accountable for overall compliance with the agreement and are required to sign the agreement (for all locations included)

- For small practices that do not have both a CMO and CEO/CFO one person may be listed in both areas

# Section A: Redistribution Agreement Request

- Supplemental COVID-19 Vaccine Redistribution Agreement will only be furnished to certain organizations and must be requested by answering the question in this section or contacting the NYS COVID-19 Vaccine Program
- Submissions will be reviewed by the NYS COVID-19 Vaccine Program to make a determination
- All locations receiving COVID-19 vaccine, constituent products, and ancillary supplies must have a completed and approved *CDC COVID-19 Vaccination Program Provider Profile* form (Section B)
- CDC does not pay for or reimburse awardees, COVID-19 vaccination provider organizations, facilities, or other entities for any redistribution beyond the initial designated primary CDC ship-to location, or for any vaccine-specific portable refrigerators and/or qualified containers and pack-outs.

COVID-19 vaccine will be shipped in minimum order quantities no smaller than 100 doses. NYS will allow some healthcare organizations to redistribute vaccine to sites not receiving direct shipments. To redistribute vaccine a COVID-19 Vaccine Redistribution Agreement must be submitted and approved. All costs associated with redistribution are the responsibility of the organization. All locations receiving redistributed vaccine must complete a Provider Profile (Section B).

Question: Are you interested in receiving a COVID-19 Vaccine Redistribution Agreement?

Yes

No

# Section A: Agreement Requirements and Signatures

When checking the Agreement Requirements box all conditions of the agreement are displayed

AGREEMENT REQUIREMENTS

**Chief Medical Officer (or Equivalent)**

Please Attest

Name \*

**Section B. CDC COVID-19 Vaccination**

Please complete and sign this form at each location. Each individual Organization must sign and stamp this form.

**ORGANIZATION IDENTIFICATION FOR IMMUNIZATION SERVICES**

Organization location name: \*

**AGREEMENT REQUIREMENTS** ✕

I understand this is an agreement between Organization and CDC. This program is a part of collaboration under the relevant state, local, or territorial immunization's cooperative agreement with CDC.

To receive one or more of the publicly funded COVID-19 vaccines (COVID-19 Vaccine), constituent products, and ancillary supplies at no cost, Organization agrees that it will adhere to the following requirements:

- Organization must administer COVID-19 Vaccine in accordance with all requirements and recommendations of CDC and CDC's Advisory Committee on Immunization Practices (ACIP).<sup>1</sup>
- Within 24 hours of administering a dose of COVID-19 Vaccine and adjuvant (if applicable), Organization must record in the vaccine recipient's record and report required information to the relevant state, local, or territorial public health authority. Details of required information (collectively, Vaccine-Administration Data) for reporting can be found on CDC's website.<sup>2</sup>

Organization must submit Vaccine-Administration Data through either (1) the immunization information system (IIS) of the state and local or territorial jurisdiction or (2) another system designated by CDC according to CDC documentation and data requirements.<sup>2</sup>

Organization must preserve the record for at least 3 years following vaccination, or longer if required by state, local, or territorial law. Such records must be made available to any federal, state, local, or territorial public health department to the extent authorized by law.

- Organization must not sell or seek reimbursement for COVID-19 Vaccine and any adjuvant, syringes, needles, or other constituent products and ancillary supplies that the federal government provides without cost to Organization.
- Organization must administer COVID-19 Vaccine regardless of the vaccine recipient's ability to pay COVID-19 Vaccine administration fees.
- Before administering COVID-19 Vaccine, Organization must provide an approved Emergency Use Authorization (EUA) fact sheet or vaccine information statement (VIS), as required, to each vaccine recipient, the adult caregiver accompanying the recipient, or other legal representative.
- Organization's COVID-19 vaccination services must be conducted in compliance with CDC's Guidance for Immunization Services During the COVID-19 Pandemic for safe delivery of vaccines.<sup>3</sup>

# Section A: Agreement Requirements and Signatures

In the HCS application an attestation box is checked to electronically sign the agreement. Both CMO and CEO/CFO must attest and type their name.

AGREEMENT REQUIREMENTS

## Chief Medical Officer (or Equivalent) Attestation

Please Attest

Name \*

Section B. CDC COVID-19 Vaccination Program Provider

## Attestation



By typing name where indicated, checking this box, and clicking the Submit button, I understand and agree that:

- I am electronically signing and filing the COVID-19 Vaccination Program Provider Agreement (“Agreement”);
- Electronically signing and filing this Agreement is the legal equivalent of having placed my handwritten signature on the submitted Agreement and this attestation;
- In addition to certifying that all relevant officers, directors, employees, and agents of the Organization involved in handling COVID-19 vaccine understand and will comply with this Agreement’s requirements, I further certify such individuals have been directed to comply with New York State law, including but not limited to laws governing scope of practice related to administration of vaccinations, where applicable.
- By entering this Agreement, Organization does not become a State government contractor.
- I am affirming that the statements made in this Agreement are true under the penalties of perjury and are subject to verification.

# Section B: Organization Identification for Individual Locations

In the agreement “locations” refer to each physical site (i.e. practice, clinic, hospital, pharmacy) that will receive and administer COVID-19 vaccine.

## Section B. CDC COVID-19 Vaccination Program Provider Profile Information

Please complete and sign this form for your Organization location. If you are enrolling on behalf of one or more other affiliated Organization vaccination locations, complete and sign this form for each location. Each individual Organization vaccination location must adhere to the requirements listed in Section A.

### ORGANIZATION IDENTIFICATION FOR INDIVIDUAL LOCATIONS

Organization location name: \*

Required

Will another Organization location order COVID-19 vaccine for this site?

Yes

Organization name: \*

Required

No

If the location is planning to have vaccine redistributed from another location rather than receiving vaccine directly shipped from the CDC, they must answer ‘Yes’ to this question and give the name of the location that will order vaccine for them

# Section B: Primary and Back-up COVID-19 Vaccine Coordinator

- The vaccine coordinator listed on this form is the individual who will be responsible for receiving vaccine shipments, monitoring storage unit temperatures, managing inventory, etc.
- It is encouraged that these individuals have New York State Immunization Information System (NYSIIS) administrative user access for the location’s ordering and inventory management but another person at the location may be the NYSIIS user

## CONTACT INFORMATION FOR LOCATION'S PRIMARY COVID-19 VACCINE COORDINATOR

First Name: *	<input type="text" value="Required"/>	Last Name: *	<input type="text" value="Required"/>
Middle Initial	<input type="text" value="Optional"/>		
Telephone: *	<input type="text" value="(999) 999-9999? x99999"/>	Email: *	<input type="text" value="Required"/>

## CONTACT INFORMATION FOR LOCATION'S BACK-UP COVID-19 VACCINE COORDINATOR



First Name: *	<input type="text" value="Required"/>	Last Name: *	<input type="text" value="Required"/>
Middle initial	<input type="text" value="Optional"/>		
Telephone: *	<input type="text" value="(999) 999-9999? x99999"/>	Email: *	<input type="text" value="Required"/>

# Section B: Organization Location Addresses

## Organization location address for receipt of COVID-19 Vaccine Shipments

- This **must be accurate** since this is where deliveries will be made



### ORGANIZATION LOCATION ADDRESS FOR RECEIPT OF COVID-19 VACCINE SHIPMENTS

Street address 1: *	Required	Street address 2:	Optional
City: *	Required	County: *	Select county 
State: *	New York 	ZIP code: *	99999
Telephone: *	(999) 999-9999? x999999	Fax:	(999) 999-9999

## Organization address of location where COVID-19 vaccine will be administered

- This will usually be the same as your delivery address

### ORGANIZATION ADDRESS OF LOCATION WHERE COVID-19 VACCINE WILL BE ADMINISTERED (IF SAME AS RECEIVING LOCATION CHECK HERE)

Street address 1: *	Required	Street address 2:	Optional
City: *	Required	County: *	Select county 
State: *	New York 	ZIP code: *	99999
Telephone: *	(999) 999-9999? x999999	Fax:	(999) 999-9999

# Section B: Days and Times for COVID-19 Vaccine Shipments

Providers **must** be available to accept shipments during all hours selected

DAYS AND TIMES VACCINE COORDINATORS ARE AVAILABLE FOR RECEIPT OF COVID-19 VACCINE SHIPMENTS

(valid entries for From and To are in this range : 00-12 (hours) and 00-59 (minutes))

Must be open at least one day

	Closed	From	To
Monday	<input type="checkbox"/>	08:30 AM 08 : 30 AM	
Tuesday	<input type="checkbox"/>		
Wednesday	<input type="checkbox"/>		
Thursday	<input type="checkbox"/>		
Friday	<input type="checkbox"/>		

Same hours for all days



This box enables you to apply hours you have listed for one day to all days not marked as closed



# Section B: Provider Type

Choose the provider type that best describes this location

COVID-19 VACCINATION PROVIDER TYPE FOR THIS LOCATION (SELECT ONE)

Select Provider Type

- Commercial vaccination service provider
- Corrections/detention health services
- Health center – community (non-Federally Qualified Health Center/non-Rural Health Clinic)
- Health center – migrant or refugee
- Health center – occupational
- Health center – STD/HIV clinic
- Health center – student

HIS I

This is just a portion of the 28 provider type options. Use the scroll bar to see other choices.

If your type is not listed, you may choose 'Other' and type a description in the box that appears.

# Section B: Setting(s) Where this Location will Administer COVID-19 Vaccine

Select all settings you plan to administer COVID-19 vaccine

SETTING(S) WHERE THIS LOCATION WILL ADMINISTER COVID-19 VACCINE

Choose

Q | X

- Childcare or daycare facility
- College, technical school, or university
- Community center
- Correctional/detention facility
- Health care provider office, health center, medical practice
- Hospital (i.e., inpatient facility)
- In-home

This is just a portion of the setting choices. Use the scroll bar to see other choices.

If a setting is not listed, you may choose 'Other' and type a description in the box that appears.

# Section B: Patient Population

Report the number of patients/clients routinely served in each age category and average unique patients/week. This information will help us determine capacity, so enter a number if possible rather than 'unknown'

## APPROXIMATE NUMBER OF PATIENTS/CLIENTS ROUTINELY SERVED BY THIS LOCATION

Number of children 18 years of age and younger:

*(Enter "0" if the location does not serve this age group.)*

Unknown

Number of adults 19–64 years of age:

*(Enter "0" if the location does not serve this age group.)*

Unknown

Number of adults 65 years of age and older:

*(Enter "0" if the location does not serve this age group.)*

Unknown

Number of unique patients/clients seen per week, on average:

Unknown

Not applicable (e.g., for commercial vaccination service providers)

You must enter a number between 0 and 99,999 or check 'unknown'

# Section B: Influenza Vaccination Capacity

Report the number of influenza vaccine doses administered during peak week of 2019-20 influenza season. This information will help us determine peak administration capacity, so enter a number if possible rather than 'unknown'

## INFLUENZA VACCINATION CAPACITY FOR THIS LOCATION

Number of influenza vaccine doses administered during the peak week of the 2019–20 influenza season:

*(Enter "0" if no influenza vaccine doses were administered by this location in 2019-20)*


- Unknown
- Not applicable

You must enter a number between 0 and 999,999 or check 'Unknown' or 'Not applicable'


# Section B: Population(s) Served by this Location

Select all populations you regularly serve or plan to target for COVID-19 vaccination. This information will help us identify whether you serve a group prioritized for vaccination.

POPULATION(S) SERVED BY THIS LOCATION (SELECT ALL THAT APPLY)

Choose 

- General pediatric population
- General adult population
- Adults 65 years of age and older
- Long term care facility residents (nursing home, assisted
- Health care workers
- Critical infrastructure/essential workers (e.g., education, l
- Military – active duty/reserves



This is just a portion of the population choices. Use the scroll bar to see other choices.

If a population is not listed, you may choose 'Other' and type a description in the box that appears.

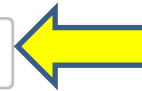
# Section B: Reporting Vaccine Administration Data (New York State Immunization Information System)

You are required to report administration of COVID-19 vaccine within 24 hours.

Does your org currently report vaccine administration data to NYSIIS?

Yes List NYSIIS Org ID

Required



No

Not applicable

If "No," please explain planned method for reporting vaccine administration data to the jurisdiction's IIS or other designated system as required:

Required

If you answer 'Yes' a box will pop up requiring you to enter your NYSIIS Org ID. This is your unique ID and can be found in the NYSIIS Edit Org screen. It is up to 6 digits (see next slide on how to find NYSIIS Org ID)

If your organization is not currently set up in NYSIIS, select No. The box above will appear to explain how you will report. NYSIIS is required for ordering vaccine, managing inventory, and reporting doses administered. Your organization will be entered in NYSIIS upon enrollment.

# How to find your Org ID in NYSIIS

1. Log into NYSIIS-Production and access the NYSIIS Portal page
  - a) If a user has access to more than one org in NYSIIS, they will automatically land on the NYSIIS Portal page when logging in.
  - b) If a user has access to only one org in NYSIIS, they bypass the Portal and land on the homepage for their org when they click NYSIIS – Production from HCS. These users need to click the ‘Mange Access/Account’ tab to access the NYSIIS Portal.

home **manage access/account** forms related links logout help desk

organization Baynard Health Clinic • user Lori Isabella-Rhoades • role Admin User (Public Health)

Announcements

10/31/2012 ~ [Hurricane Sandy Preparedness, Recovery, and FAQ Links](#)

NYSIIS Portal Page

2. On the left side menu panel of the NYSIIS Portal Page, click ‘Edit Organization.’ **Note** – this menu item is only available to Administrative Users in NYSIIS.

**nysiis**

Training Region  
\*\*\*\*\*  
Welcome  
Lori Isabella-Rhoades  
Logout

**Applications**  
NYSIIS

**Manage My Account**  
Edit My User Account

**Manage Access**  
Add User  
Add Multiple Users  
Edit User  
List Organizations  
**Edit Organization**

HOME FORMS RELATED LINKS

[NYS Department of Health](#)  
[Test County DOH](#)  
[Baynard Health Clinic](#)

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# How to find your Org ID in NYSIIS

3. Click the org you'd like to view

4. Org ID is the first field on the Edit Organization screen

## Edit Organizations Screen

**New York State Immunization Information System**

HOME FORMS RELATED LINKS

### Edit Organizations

Select your organization's name to view and/or update information.  
Note: parent organization names are marked with an "\*".

To locate a specific organization, enter a VFC PIN or NYSIIS Organization ID and click Search

VFC PIN:       NYSIIS Org Id:       Search

Index    A B C D E F G H I J K L M N O P Q R S T U V W X Y Z

Name	City	Main Contact	Phone
<a href="#">Baynard Health Clinic</a>	SCHENECTADY	Shelby Tanker	<a href="tel:518-555-3100">518-555-3100</a>
<a href="#">Test County DOH</a>	ALBANY	mickey mouse	<a href="tel:518-888-8888">518-888-8888</a>

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## Edit Organization

**New York State Immunization Information System**

HOME Edit Organization

### Edit Organization

Org Id **450**

Org Classification Child

Type Private Practice, including Solo, Group, HMO

UPHN  Yes  No

UPHN Type

UPHN ID

UPHN Partner



# Section B: Storage Unit Capacity

You must have capacity for at least one storage unit type. Which COVID-19 vaccine product(s) you may order will be based on this capacity.

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 VACCINE SEASON) AT THE FOLLOWING TEMPERATURES

Refrigerated (2°C to 8°C)

No Capacity

Approximately

additional 10-dose MDVs

Frozen (-15° to -25°C)

No Capacity

Approximately

additional 10-dose MDVs

Ultra-frozen (-60° to -80°C)

No Capacity

Approximately

additional 10-dose MDVs



You must either select 'No Capacity' or 'Approximately' for each type (approximately means you do have capacity for this storage unit type)

If you choose 'Approximately' you must enter a capacity number. Make sure this is **TOTAL** capacity – if you have more than one unit that could store COVID-19 vaccine, add capacity for all units of that type/temperature.  
**IMPORTANT: This is number of 10-dose multidose vials, not total doses (i.e. if you have capacity for 5,000 doses you would enter 500 in the box)**

# Section B: Storage Unit Details for this Location

Please add information for each storage unit that will be used for storing COVID-19 vaccine at this location. You should list each unit you included in the storage unit capacity question.

## STORAGE UNIT DETAILS FOR THIS LOCATION

List brand/model/type of storage units to be used for storing COVID-19 vaccine at this location

Type of unit \*

Make/model \*

Grade of unit \*

[+ Add Storage Unit](#)

Use the Add Storage Unit button to add another unit

You should have at least one unit for each type listed in the capacity question (i.e. if you said you have freezer capacity you should have details on at least one freezer)

Type of unit = Refrigerator, Freezer, or Ultra Cold  
 Make/model = short description of unit  
 Grade of unit = household/commercial combination, household/commercial stand alone, or Pharmaceutical

# Section B: Location Storage Attestation

In the HCS application an attestation box is checked to electronically sign the agreement and attest that each unit listed will be monitored for safe temperatures. The medical/pharmacy director or vaccine coordinator must attest and type their name.

I attest that each unit listed will maintain the appropriate temperature range indicated above:

Medical/pharmacy director or location's vaccine coordinator name \*

Required

## Attestation

By typing name where indicated, checking this box, and clicking the Submit button, I understand and agree that:

- I am electronically signing and filing the COVID-19 Vaccination Program Provider Agreement (“Agreement”);
- Electronically signing and filing this Agreement is the legal equivalent of having placed my handwritten signature on the submitted Agreement and this attestation;
- In addition to certifying that all relevant officers, directors, employees, and agents of the Organization involved in handling COVID-19 vaccine understand and will comply with this Agreement’s requirements, I further certify such individuals have been directed to comply with New York State law, including but not limited to laws governing scope of practice related to administration of vaccinations, where applicable.
- By entering this Agreement, Organization does not become a State government contractor.
- I am affirming that the statements made in this Agreement are true under the penalties of perjury and are subject to verification.

# Part B: Providers Practicing at this Facility

List all healthcare provider at the location with prescribing authority

PROVIDERS PRACTICING AT THIS FACILITY *(additional spaces for providers at end of form)*

+ Add Provider

**Instructions:** List below all licensed healthcare providers at this location who have prescribing authority (i.e., MD, DO, NP, PA, RPh).

Provider first name \*

Required

Provider middle initial

Optional

License Number \*

Required

Provider last name \*

Required

Title \*

Select Profession

Title is required.

Use the Add Provider button to add another to the location. Organizations must report all providers that will prescribe or issue a standing order for COVID-19 vaccination. All other healthcare providers with prescribing authority are encouraged to be included.

Title dropdown is matched to SED license type to enable license verification. Options are listed on the next slide.

# SED Profession Codes in dropdown

Pharmacist

Pharmacist, limited license

Registered Physician Assistant

Nurse Practitioner, Adult Health

Nurse Practitioner, College Health

Nurse Practitioner, Community Health

Nurse Practitioner, Family Health

Nurse Practitioner, Gerontology

Nurse Practitioner, Neonatology

Nurse Practitioner, Obstetrics &  
Gynecology

Nurse Practitioner, Oncology

Nurse Practitioner, Pediatrics

Nurse Practitioner, Perinatology

Nurse Practitioner, Psychiatry

Nurse Practitioner, School Health

Nurse Practitioner, Women's Health

Nurse Practitioner, Acute Care

Nurse Practitioner, Palliative Care

Nurse Practitioner, Holistic medicine

Nurse Practitioner, Anesthesia

Medicine

Medicine, limited license

# Addendum: Non-established Patients

This question is to assess capacity to vaccinate individuals that are not established patients, including priority populations, through walk-in clinics, mass vaccination clinics, employee clinics, etc.

Is your facility willing to vaccinate individuals that are not established patients (walk-in clinics, mass vaccination clinics, employee clinics, etc.)? \*

- Yes
- No

If you answer 'Yes' a table will appear to estimate capacity for targeted groups (see next slide)

# Addendum: Non-established patient population estimates

Please estimate number of individuals that are not established patients you may be able to vaccinate through additional clinics:

	Age 0–18	Age 19–64	Age 65+	Total	
<b>Health Care Worker Estimates</b>					
ICU Personnel	<input type="text"/>	<input type="text"/>	<input type="text"/>	This column will auto total based on input in other cells	
Emergency Department Personnel	<input type="text"/>	<input type="text"/>	<input type="text"/>		
High-risk Personnel, not listed above	<input type="text"/>	<input type="text"/>	<input type="text"/>		
Other (non high-risk) Health Care Workers	<input type="text"/>	<input type="text"/>	<input type="text"/>		
EMT/First Responders	<input type="text"/>	<input type="text"/>	<input type="text"/>		
<b>Total Health Care Workers</b>	This row will automatically total based on data input in all rows above				<input type="text"/>
<b>Employee clinics for essential workers</b>	<input type="text"/>	<input type="text"/>	<input type="text"/>		
<b>Clinics for medically high-risk</b>	<input type="text"/>	<input type="text"/>	<input type="text"/>		
<b>Clinics for general population</b>	<input type="text"/>	<input type="text"/>	<input type="text"/>		

Health Care Workers are paid and unpaid persons serving in healthcare settings who have the potential for direct or indirect exposure to patients or infectious material.

High-risk personnel may include those caring for COVID-19 patients, cleaning areas where COVID-19 patients are admitted and treated, and performing procedures with high risk of aerosolization such as endotracheal intubation, bronchoscopy, suctioning, turning the patient to the prone position, disconnecting the patient from the ventilator, invasive dental procedures and exams, invasive specimen collection, and cardiopulmonary resuscitation.

Essential workers: <https://esd.ny.gov/guidance-executive-order-2026>

Medically high-risk conditions:

- Cancer
- Chronic kidney disease
- COPD (chronic obstructive pulmonary disease)
- Immunocompromised state (weakened immune system) from solid organ transplant
- Obesity (body mass index [BMI] of 30 or higher)
- Serious heart conditions, such as heart failure, coronary artery disease, or cardiomyopathies
- Sickle cell disease
- Type 2 diabetes mellitus
- COPD (chronic obstructive pulmonary disease)
- COPD (chronic obstructive pulmonary disease)

Estimates entered here are number of total individuals you may be able to vaccinate through mass vaccination and other clinic that are either targeted for a specific group or open to the public

If you are not intending to hold targeted clinics for specific groups listed above, please enter your estimates in the Clinics for General Population category.

# Addendum: High Throughput Capacity Assessment

Some vaccines will have a minimum order quantity of 1,000 doses with ultra cold storage. Cold chain can be maintained in the shipping container with dry ice replenishment for up to 10 days. To minimize waste this vaccine can only go to large, high-throughput locations unless there is ultra cold storage capacity.

Can your facility administer 1000 doses of COVID-19 vaccine over the course of 10 days? \*

- Yes
- No
- Unknown



# Addendum: High Throughput Capacity Assessment

Additional questions assess number of health care personnel (HCP) this location can vaccinate within 10 days and the format of point-of-distribution (POD).

Closed POD = will vaccinate your own HCP only

Open POD = will vaccinate your own HCP as well as HCP from other organizations

How many health care personnel could your facility vaccinate within 10 days? \*

Format of distribution (POD)? \*

Closed POD  Yes  
 No  
 Unknown

Open POD  Yes  
 No  
 Unknown

These questions are targeted mainly toward early enrolled providers such as hospitals and local health departments, but may be answered by all. If they do not apply to your provider type, enter '0' in the box and select 'No' for distribution type questions

# Add Another Location Provider Profile

**IMPORTANT!!** There is currently no functionality to save an incomplete form (coming soon!) or to retrieve a previously submitted form. You must enter all locations (Section B) under the organization *together*. Once you click Submit you will not be able to return to your form. If you do click submit and need to add another location you will have to fill out the PDF enrollment form and submit it via email for state users to add to your organization.

You must submit a Provider Profile (Section B) for every provider location receiving COVID-19 vaccine under this organization. Press the add button to complete another Provider Profile. Do not press submit until all locations for this organization have been entered.

+ Add Another Location Provider Profile (Section B)

Submit

# Submit Your Enrollment

When you click the Submit button you will either receive a message that error(s) must be corrected (they will appear in RED throughout the application) or you will receive a notice that it has been submitted along with a button to download a copy of the completed enrollment.

✓ Thank you for submitting your COVID-19 Vaccine Program Provider Agreement and Profile. Staff will review your submission and make a determination. Please retain your Reference ID 100124 associated with this submission along with a copy of your submission by using the download function. Please monitor your inbox for emails regarding enrollment status and next steps.

Download PDF

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

Your message will contain a Reference ID. Please retain this number for communicating with the NYS COVID-19 Vaccine Program regarding your enrollment.

# Downloaded Agreement

The first page of your downloaded agreement will look like this. Note that the Reference ID that was given on the submit message is at the top of the form.

## CDC COVID-19 Vaccination Program Provider Agreement



Reference ID: 100124

**Please complete Sections A and B of this form as follows:**

The Centers for Disease Control and Prevention (CDC) greatly appreciates your organization's (Organization) participation in the CDC COVID-19 Vaccination Program. Your Organization's chief medical officer (or equivalent) and chief executive officer (or chief fiduciary) – collectively, Responsible Officers – must complete and sign the CDC COVID-19 Vaccination Program Provider Requirements and Legal Agreement (Section A). CDC COVID-19 Vaccination Program Provider Profile Information (Section B) must be completed for each vaccination Location covered under the Organization listed in Section A.

**Section A. COVID-19 Vaccination Program Provider Requirements and Legal Agreement**



# Questions?



Questions can be emailed to [COVID19Vaccine@health.ny.gov](mailto:COVID19Vaccine@health.ny.gov)