

Submitting the CDC COVID-19 Vaccination Program Provider Agreement to the South Dakota Department of Health

- ✓ There are 2 sections in the CDC COVID-19 Vaccination Program Provider Agreement: Section A and Section B.
 - Section A (CDC COVID-19 Vaccination Program Provider Requirements and Legal Agreement) must be completed and signed by your organization’s chief medical officer (or equivalent) and chief executive officer (or chief fiduciary). Section A will be completed once by each organization.
 - Section B (CDC COVID-19 Vaccination Program Provider Profile Information) must be completed for each vaccination location covered under the Organization listed in Section A.
- ✓ The forms do not include a “Save” button. Each time you progress to a new screen, your previous answers are saved. Each form should be completed in one sitting.
- ✓ You will have to click the same link for each form that you want to submit. For example, to begin Section B for a vaccination location after submitting Section A for an organization, you will click on the link again and start from the beginning.

Completing Section A:

1. After clicking on the link you were provided, you will see this screen:

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.

Select one option below to begin **Section A** or **Section B**:

Section A: I am a chief medical officer, chief executive officer, or other Responsible Officer who must complete the CDC COVID-19 Vaccination Program Provider Requirements and Legal Agreement (as described above) for my organization.

Section B: I must complete the CDC COVID-19 Vaccination Program Provider Profile Information (as described above) for a vaccination location.



Click the box for Section A and then click the forward arrow.

2. Enter the requested information for your organization. Zip codes can be entered in the 5-digit or 9-digit format.
3. Enter the requested information for the chief medical officer (or equivalent). Zip codes can be entered in the 5-digit or 9-digit format.
4. Enter the requested information for the chief medical officer (or chief fiduciary). Zip codes can be entered in the 5-digit or 9-digit format.
5. The Responsible Officers should read the Agreement Requirements carefully, including information provided in embedded links, and then click the forward arrows on the next 2 screens.

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:

1. Organization must administer ~~COVID-19 Vaccines~~ in accordance with all requirements and recommendations of CDC and CDC's Advisory Committee on Immunization Practices (ACIP). [<https://www.cdc.gov/vaccines/hcp/acip-recs/index.html>]

Make sure you are familiar with the information contained in embedded links and that you stay up-to-date with changing guidance.

By signing this form, I certify that all relevant officers, directors, employees, and agents of Organization involved in handling COVID-19 Vaccine understand and will comply with the agreement requirements listed above and that the information provided in sections A and B is true.

The above requirements are material conditions of payment for COVID-19 Vaccine-administration claims submitted by Organization to any federal healthcare benefit program, including but not limited to Medicare and Medicaid, or submitted to any HHS-sponsored COVID-19 relief program, including the Health Resources & Services Administration COVID-19 Uninsured Program. Reimbursement for administering COVID-19 Vaccine is not available under any federal healthcare program if Organization fails to comply with these requirements with respect to the administered COVID-19 Vaccine dose. Each time Organization submits a reimbursement claim for COVID-19 Vaccine administration to any federal healthcare program, Organization expressly certifies that it has complied with these requirements with respect to that administered dose.

6. The chief medical officer's last name, first name, and middle initial (if applicable) that were entered previously will pre-populate on this screen. Verify that they are correct; if they aren't, use the back arrow to return and edit your entries on the earlier screen. The chief medical officer must sign in the signature box after downloading and printing the form. You will have an opportunity to download the form for printing after its completion.

The screenshot shows a form titled "Chief Medical Officer (or Equivalent)". It contains three text input fields for "Last name" (pre-populated with "Doe"), "First name" (pre-populated with "Jane"), and "Middle initial" (pre-populated with "Q."). Below these is a "Signature" section with a note: "(Sign after printing. You will have an opportunity to download the survey as a PDF after completion.)" and a large empty text box. A "Date" field is pre-populated with "09/30/2020". At the bottom, there are two blue navigation buttons: a back arrow on the left and a forward arrow on the right, which is circled in red.

Verify that the CMO's pre-populated last name, first name, and middle initial are correct. The CMO must sign in the signature box after printing the survey following completion.

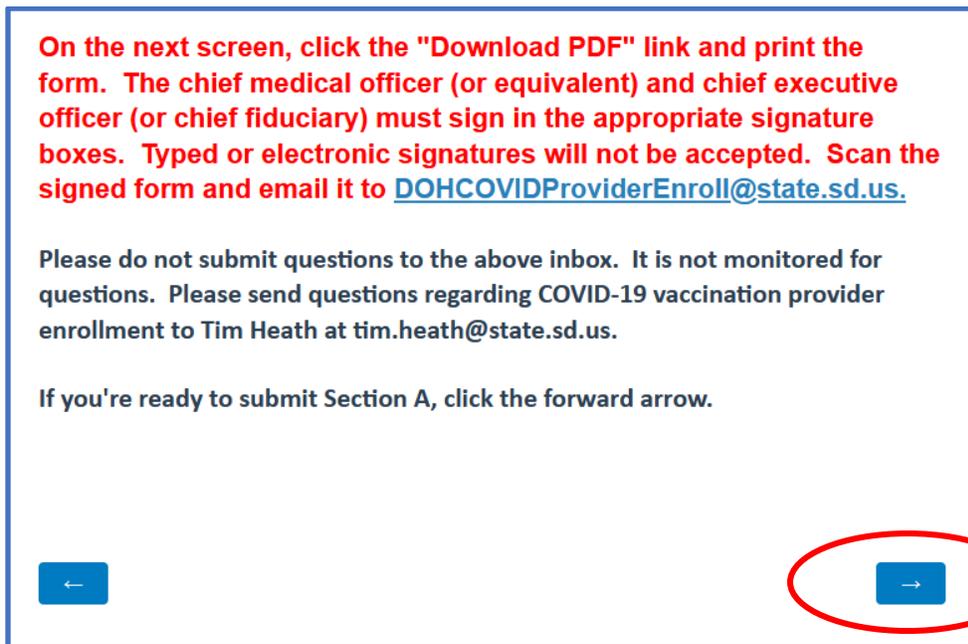
7. Repeat step #6 for the Chief Executive Officer. The chief executive officer must sign in the signature box after downloading and printing the form. You will have an opportunity to download the form for printing after its completion.

8. If you are ready to submit Section A, click the forward arrow. If not, click the back arrow to return to previous screens and edit your entries.

On the next screen, click the "Download PDF" link and print the form. The chief medical officer (or equivalent) and chief executive officer (or chief fiduciary) must sign in the appropriate signature boxes. Typed or electronic signatures will not be accepted. Scan the signed form and email it to DOHCOVIDProviderEnroll@state.sd.us.

Please do not submit questions to the above inbox. It is not monitored for questions. Please send questions regarding COVID-19 vaccination provider enrollment to Tim Heath at tim.heath@state.sd.us.

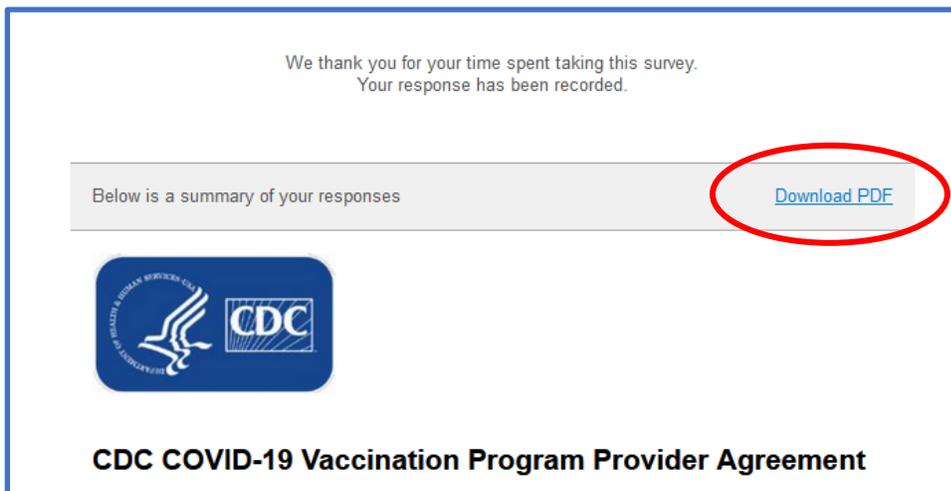
If you're ready to submit Section A, click the forward arrow.

A screenshot of a survey screen. At the top, there is a red text block with instructions. Below it is a paragraph of text. At the bottom, there are two blue navigation buttons: a back arrow on the left and a forward arrow on the right. The forward arrow button is circled in red.

9. Click the "Download PDF" link to download a copy of your completed form.

We thank you for your time spent taking this survey.
Your response has been recorded.

Below is a summary of your responses [Download PDF](#)

A screenshot of a survey completion screen. At the top, there is a thank you message. Below it is a grey bar with the text "Below is a summary of your responses" and a blue "Download PDF" link. The link is circled in red. At the bottom, there is a CDC logo and the text "CDC COVID-19 Vaccination Program Provider Agreement".

10. Print the form and have the chief medical officer sign in the signature box.

Chief Medical Officer (or Equivalent)

Last name

First name

Middle initial

Signature

(Sign in the box below after printing. You will have an opportunity to download the form for printing after completion. Typed or electronic signatures will not be accepted.)

Date

After downloading and printing the form, the chief medical officer signs in the signature box.



11. Repeat step #10 for the chief executive officer. He/she must also sign in the signature box.

12. After both Responsible Officers have signed the form, scan it and email to DOHCOVIDProviderEnroll@state.sd.us.

13. The Department of Health will send a South Dakota COVID-19 Vaccination Identification Number to the organization email address provided on the form. This ID number is unique to your organization and is required for completion of Section B of the COVID-19 Vaccination Program Provider Agreement.

14. To complete Section B of the CDC COVID-19 Vaccination Program Provider Agreement for a vaccination location, click the same link you used to access Section A and follow the instructions below.

Completing Section B:

1. After clicking on the link you were provided, you will see this screen:

The screenshot shows the CDC COVID-19 Vaccination Program Provider Agreement form. At the top left is the CDC logo. The title is "CDC COVID-19 Vaccination Program Provider Agreement". Below the title, it says "Please complete Sections A and B of this form as follows:". The main text explains that the CDC appreciates the organization's participation and that the chief medical officer and chief executive officer must complete and sign the agreement. It states that CDC COVID-19 Vaccination Program Provider Profile Information (Section B) must be completed for each vaccination location. Below this, it says "Select one option below to begin Section A or Section B:". There are two options: "Section A: I am a chief medical officer, chief executive officer, or other Responsible Officer who must complete the CDC COVID-19 Vaccination Provider Requirements and Legal Agreement (as described above) for my organization." and "Section B: I must complete the CDC COVID-19 Vaccination Program Provider Profile Information (as described above) for a vaccination location." The "Section B" option is highlighted in blue. At the bottom right, there is a blue button with a right-pointing arrow, which is circled in red.

Click the box for Section B and then click the forward arrow.

2. Enter your organization's South Dakota COVID-19 Vaccination Identification Number. This number was provided after your organization completed Section A and is in the format "SDxxxxx" (i.e., "SD" followed by 5 digits). You will use the same Organization ID number for every location covered by that organization.

The screenshot shows the "Section B. CDC COVID-19 Vaccination Program Provider Profile Information" form. It says "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. You can review Section A requirements here: [Agreement requirements for signature](#)". Below this, it says "Organization's South Dakota COVID-19 Vaccination Identification Number". A note states "This code was provided to your Organization after it completed Section A of the CDC COVID-19 Vaccination Program Provider Agreement." There is a text input field for the identification number. At the bottom left, there is a blue button with a left-pointing arrow. At the bottom right, there is a blue button with a right-pointing arrow, which is circled in red.

Enter your organization's unique COVID-19 Vaccination Identification Number and then click the forward arrow.

3. Enter the name of the individual location in the box.

4. If another location will order vaccine for this site, enter the name of the other location in the box that appears after “Yes” is selected, and click the forward arrow. If another location will not order vaccine for this site, select “No” and click the forward arrow.

ORGANIZATION IDENTIFICATION FOR INDIVIDUAL LOCATIONS

Organization Location name

Location X

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

Yes

No

Provide Organization location name

← →

If another location will order vaccine for this site, enter that location's name in the box.

5. Enter the contact information for the location's primary COVID-19 vaccine coordinator and click the forward arrow. All fields are required for proceeding to the next screen.

6. Enter the contact information for the location's back-up COVID-19 vaccine coordinator and then click the forward arrow. All fields are required for proceeding to the next screen.

7. Enter the location's address for receipt of COVID-19 vaccine shipments. Because the South Dakota Department of Health is not enrolling locations outside of South Dakota, only South Dakota counties are listed in the dropdown menu

and “South Dakota” is the only option for the “State” field. Zip codes can be entered in the 5-digit or 9-digit format.

ORGANIZATION LOCATION ADDRESS FOR RECEIPT OF COVID-19 VACCINE SHIPMENTS

Street address 1

Street address 2

City

County

State

Zip

“South Dakota” is the only option for “State,” and only South Dakota counties are listed in the “County” dropdown menu.

8. Enter the times that vaccine coordinators are available to receive COVID-19 vaccine shipments. Enter one AM time and one PM time for each day, to create a time range that a coordinator will be available. Enter time according to the 12-hour clock (i.e., not military time) in either H:MM format (e.g., 3:15) or HH:MM format (e.g., 03:15). Enter the time only (don’t include “AM” or “PM”).

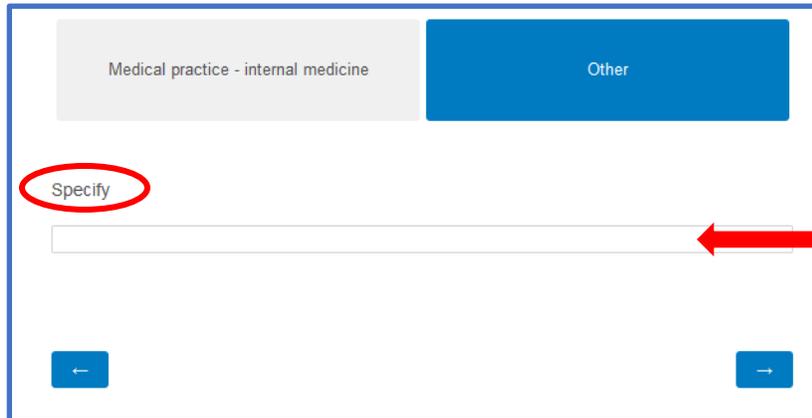
DAYS AND TIMES VACCINE COORDINATORS ARE AVAILABLE FOR RECEIPT OF COVID-19 VACCINE SHIPMENTS

Monday

AM	<input type="text" value="09:00"/>
PM	<input type="text" value="5:00"/>

Enter one AM time and one PM time for each day, in the 12-hour H:MM or HH:MM format (e.g., 3:15, 03:15).

9. Select the provider type for this location. You can only select one type. If the provider type is not listed, select “Other” and specify the type in the box that appears.

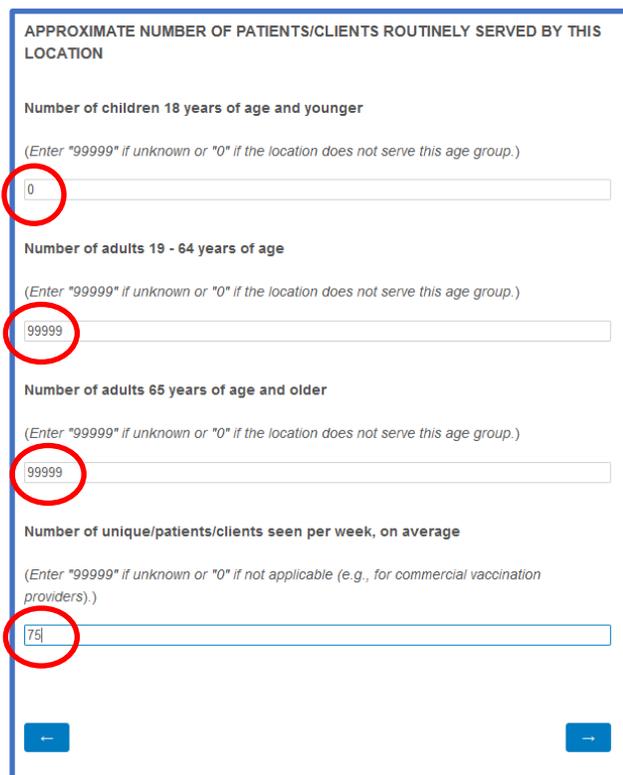


If the provider type is not listed, select “Other” and specify the type in the box that appears.

10. Select the settings where this location will administer COVID-19 vaccine. Select all the settings that apply. If one of the settings where this location will administer vaccine is not listed, select “Other” and specify the setting in the box that appears.

11. For each question on this screen, enter the estimated number of patients/clients routinely served by this location. If this location does not serve the demographic enter “0”; if this location serves the demographic but the number of patients is unknown, enter “99999.”

This hypothetical organization does not serve children ≤18 years and the number of adults served is unknown. On average, they see 75 patients per week.



Demographic	Number of patients/clients
Number of children 18 years of age and younger	0
Number of adults 19 - 64 years of age	99999
Number of adults 65 years of age and older	99999
Number of unique/patients/clients seen per week, on average	75

12. Enter the number of influenza vaccine doses administered during the peak week of the 2019-20 influenza season. If no influenza vaccine doses were administered by this location in 2019-20, enter “0”; if influenza vaccine doses were administered but the number is unknown, enter “99999.”

13. Select the populations served by this location. Select all the populations that apply. If one of the populations served by this location is not listed, select “Other” and specify the population in the box that appears.

14. If your organization currently reports vaccine administration data to the South Dakota Department of Health, select “Yes” and enter the IIS identifier in the box that appears; if you don’t know the IIS identifier, enter “Unknown.” If you don’t currently report, select “No” and explain the planned method for reporting vaccine administration data in the box that appears. If you select “Not applicable,” explain why vaccine administration data reporting does not apply to your location.

DOES YOUR ORGANIZATION CURRENTLY REPORT VACCINE ADMINISTRATION DATA TO THE STATE, LOCAL, OR TERRITORIAL IMMUNIZATION INFORMATION SYSTEM (IIS)?

Yes

No

Not applicable

If "Yes," list IIS Identifier

(If IIS Identifier is unknown, enter "Unknown.")

← →

Select the appropriate response and then answer the question that appears below.

15. Enter the approximate number of additional 10-dose multidose vials that your location can store during peak vaccination periods. If your location cannot store any doses at a particular temperature, enter “0.”

Enter the approximate number of additional 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:

(Enter "0" if no capacity)

Refrigerated (2 to 8 degrees C)	<input type="text" value="100"/>
Frozen (-15 to -25 degrees C)	<input type="text" value="50"/>
Ultra-frozen (-60 to -90 degrees C)	<input type="text" value="0"/>

← →

This hypothetical organization can store 100 refrigerated MDVs and 50 frozen MDVs. They cannot store any ultra-frozen MDVs.

16. Enter the brand, type, and model of storage units to be used for storing COVID-19 vaccine at this location in the format “brand / model / type.” If your location does not store any vaccine, click the appropriate button.

17. This screen displays a signature box that the medical/pharmacy director or location’s vaccine coordinator will sign after printing the form. You will have an opportunity to download and print the form after completion. No further action is required on this screen.

I attest that each unit listed will maintain the appropriate temperature range indicated previously.

(Medical/pharmacy director or location's vaccine coordinator must sign in the box below after printing. You will have an opportunity to download the form for printing after completion. Typed or electronic signatures will not be accepted.)

Date

← →



The medical/pharmacy director or location’s vaccine coordinator will sign in this box after printing the form. No further action is required on this screen.

18. Enter the name, title, and license number for all licensed health care providers at this location who have prescribing authority. This may include doctors, nurse practitioners, physician assistants, and registered pharmacists. If you have more than one provider to enter, select “Yes” to enter additional providers.

PROVIDERS PRACTICING AT THIS FACILITY

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

Provider 1

Last Name

First Name

Title

MD (Medical Doctor)

DO (Doctor of Osteopathy)

NP (Nurse Practitioner)

PA (Physician Assistant)

RPh (Registered Pharmacist)

Other

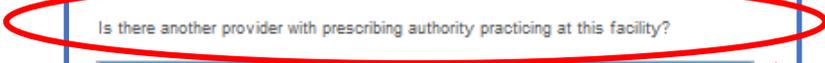
License Number

Is there another provider with prescribing authority practicing at this facility?

Yes

No

To enter additional providers with prescribing authority, select “Yes” and click the forward arrow.



19. When you have entered all providers with prescribing authority at your location, select “No” and click the forward arrow.

Last Name

First Name

Title

MD (Medical Doctor)

DO (Doctor of Osteopathy)

NP (Nurse Practitioner)

PA (Physician Assistant)

RPh (Registered Pharmacist)

Other

License Number

Is there another provider with prescribing authority practicing at this facility?

Yes

No

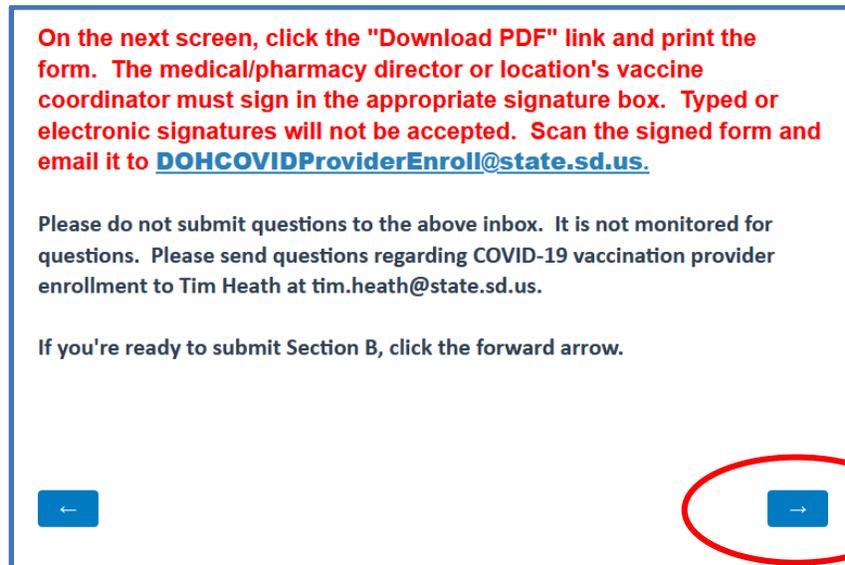


20. If you are ready to submit Section B, click the forward arrow. If not, click the back arrow to return to previous screens and edit your entries.

On the next screen, click the "Download PDF" link and print the form. The medical/pharmacy director or location's vaccine coordinator must sign in the appropriate signature box. Typed or electronic signatures will not be accepted. Scan the signed form and email it to DOHCOVIDProviderEnroll@state.sd.us.

Please do not submit questions to the above inbox. It is not monitored for questions. Please send questions regarding COVID-19 vaccination provider enrollment to Tim Heath at tim.heath@state.sd.us.

If you're ready to submit Section B, click the forward arrow.

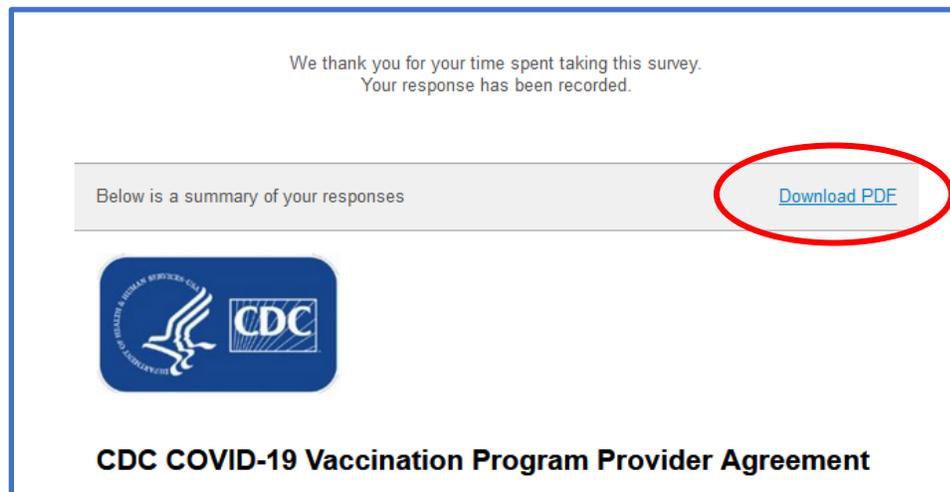


21. Click the "Download PDF" link to download a copy of your completed form.

We thank you for your time spent taking this survey.
Your response has been recorded.

Below is a summary of your responses

[Download PDF](#)



CDC COVID-19 Vaccination Program Provider Agreement

22. Print the form and have the medical/pharmacy director or location's vaccine coordinator sign in the signature box attesting that that he/she will maintain the appropriate temperature range listed previously on the form.

I attest that each unit listed will maintain the appropriate temperature range indicated previously.

(Medical/pharmacy director or location's vaccine coordinator must sign in the box below after printing. You will have an opportunity to download the form for printing after completion. Typed or electronic signatures will not be accepted.)



Date

10/01/2020

After printing the form, the medical/pharmacy director or vaccine coordinator signs in the signature box.



23. After the medical/pharmacy director or vaccine coordinator has signed the form, scan it and email to DOHCOVIDProviderEnroll@state.sd.us.

24. To complete forms for additional locations, re-click the link you used to access this form and start at the beginning. You will have to click the link again for every form that you want to submit.

For questions related to COVID-19 vaccination provider enrollment in South Dakota, please contact Tim Heath at tim.heath@state.sd.us.