PROVIDER SITE ENROLLMENT AGREEMENT

State Form 52306 (R4 / 10-25)
INDIANA DEPARTMENT OF HEALTH, IMMUNIZATION PROGRAM

Internal Use Only
IRMS
Facility
Online Date

INSTRUCTIONS: 1. *Complete this form.*
2. *Return both pages via email to: CHIRPAccess@health.in.gov*
3. *Immunization Dept.; 2 North Meridian Street, Section 6A, Indianapolis, IN 46204*

PROVIDER SITE ENROLLMENT

To participate in the Children and Hoosiers Immunization Registry (*CHIRP*)

CHIRP is an Internet-based immunization registry operated by the Immunization Program of the Indiana Department of Health (*IDOH*). Enrolled health care providers can obtain immunization information for patients, including tracking and recall. Patient information is confidential and only available to the authorized users.

The immunization records of all children and adults in Indiana may be included in the system without consent. An individual, parent or guardian may withdraw their information from CHIRP at any time. Participation in CHIRP is voluntary. CHIRP is developed under the authority of Indiana Code §16-38-5.

As a condition of participating in CHIRP, the above Provider enters into this agreement with the Indiana Department of Health, and agrees to the following:

- To use CHIRP only for the immunization needs of patients. The Provider and his or her staff will access the registry
  - to assure adequate immunization,
  - to avoid unnecessary immunizations,
  - to confirm compliance with mandatory immunization requirements,
  - to control disease outbreaks, or
  - to conduct ongoing or special immunization coverage assessments.
- If this agreement is violated by any use of the system in an unauthorized manner, IDOH reserves the right to terminate access to the system.
- The Provider shall abide by the requirements in Attachment A, CHIRP Confidentiality Agreement, which is incorporated by reference into this agreement. Each staff member needing access to CHIRP must sign the Individual User Agreement and Confidentiality Statement, which must be kept in the employee's Personnel File.
- The Provider acknowledges that unauthorized disclosure of confidential information may result in civil penalties. The Provider will take all reasonable steps to assure employee compliance with confidentiality requirements.
- The Provider shall cooperate with IDOH in notifying parents or guardians about the system. Brochures and posters will be available at no cost to the Provider.
- The Provider shall furnish specified demographic and immunization information about patients receiving immunizations promptly, striving for submission within one week after immunization administration.
- The Provider shall allow the parents or guardians to inspect, copy, and if necessary, amend or correct their own children's immunization records if he/she demonstrates that such records are incorrect. This corrected information shall be entered into CHIRP or a local database and sent to CHIRP.

Reset Form

PROVIDER SITE ENROLLMENT (*To participate in the Children and Hoosiers Immunization Registry*)

Name of the Organization: _____

Organization Type: ☐ Private Practice ☐ Public Clinic ☐ Public School ☐ Private School
☐ Hospital ☐ Child Care Center* ☐ Head Start* ☐ Long-Term Care
☐ Pharmacy

Other: _____

How many facilities do you have? _____

Will additional facilities be submitting enrollments? ☐ YES ☐ NO ☐ N/A

How will you submit data to CHIRP: ☐ Direct Data Entry ☐ Electronic Import ☐ IHIE

Is this facility a VFC (*Vaccine for Children*) provider? ☐ YES ☐ NO PIN # _____

Facility Name: _____

Facility Address: _____

_____

Facility Contact: _____

Telephone: _____ County: _____

FAX: _____ E-Mail: _____

*Licensed Child Care Centers and Licensed Head Start Centers only.

Signing this form signifies that you are in agreement with the items outlined on page one of this form. Please sign, keep a copy for yourself, and email the form to CHIRPAccess@health.in.gov or mail the original to the Indiana Department of Health, Immunization Program #6A-22, 2 N. Meridian St., Indianapolis, IN 46204

_____ _____
Signature of Provider or Authorized Representative Date *(month, day, year)*

_____ _____
Printed Name and Title Authorized Representative Date *(month, day, year)*

PRACTICE INFORMATION
Does your facility administer vaccines currently? ☐Yes ☐No

ESTIMATED NUMBER OF PATIENTS
All patient records:
Age range of patients seen: _____
Average number of vaccinations given_____ per day_____ per week*
Are you a birthing hospital? ☐Yes ☐No
If yes, average number of births per month: _____

AGE GROUPS BY INSURANCE ACCEPTED

	Accepts uninsured or underinsured patients	Accepts patients with private insurance	Accepts patients with Medicaid	Accepts patients with CHIP
Children	☐	☐	☐	☐
Adults	☐	☐	☐	☐

Location's youngest age allowed:_____

Location properties:
☐ School location
☐ Health department
☐ Pharmacy
☐ Kroger
☐ Exclusive access (in-patient, prisons, etc.)
☐ Specialty care (birthing hospitals, STD clinics, etc.)
☐ Accepts private/commercial insurance
☐ Birthing location

ELECTRONIC DATA EXCHANGE
Indicate your interest in sending data from your EHR to CHIRP via HL7. If answering in the affirmative, please provide your EHR information and contacts

Are you interested in establishing an HL7 connection to CHIRP? ❒Yes ❒No
Are you a participant in IHIE? ❒Yes ❒No

Electronic Health Record Software
Name:_____ Vendor:_____Phone:_____

EHR Vendor Contact
Name:_____ Phone: _____Email:_____

Organization Technical Contact
Name:_____ Phone:_____Email:_____

PARTICIPATION IN THE VFC PROGRAM
The Vaccines for Children (VFC) program provides vaccines to children whose parents or guardians may not be able to afford them. For more information, visit
https://www.in.gov/health/immunization/vaccines-for-children/

Are you interested in joining the VFC program to receive state-supplied vaccines?
☐Yes ☐No