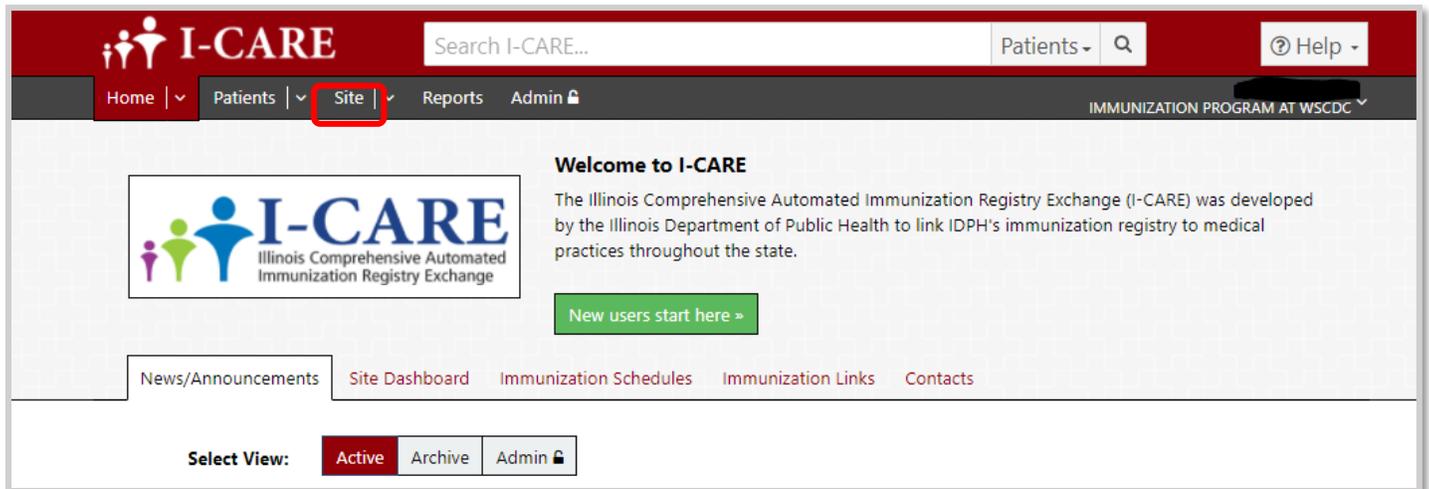


Instructions for Completing COVID-19 Vaccine Provider Enrollment in I-CARE

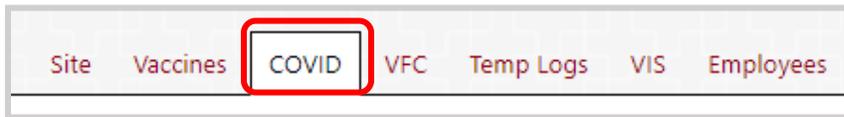
ACCESS THE COVID ENROLLMENT MATERIALS IN I-CARE

1. Log on to I-CARE

- Upon logging in you will be on the Home News/Announcements section, select the **Site** tab from the menu bar

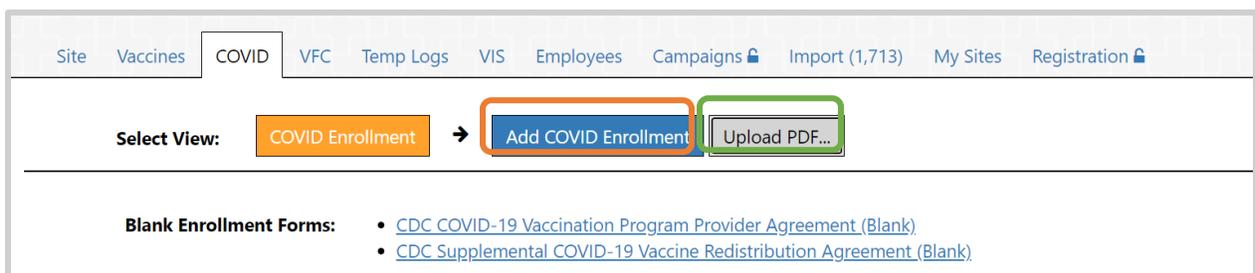


2. For COVID-19 Vaccine Provider Enrollment, choose the “COVID” tab



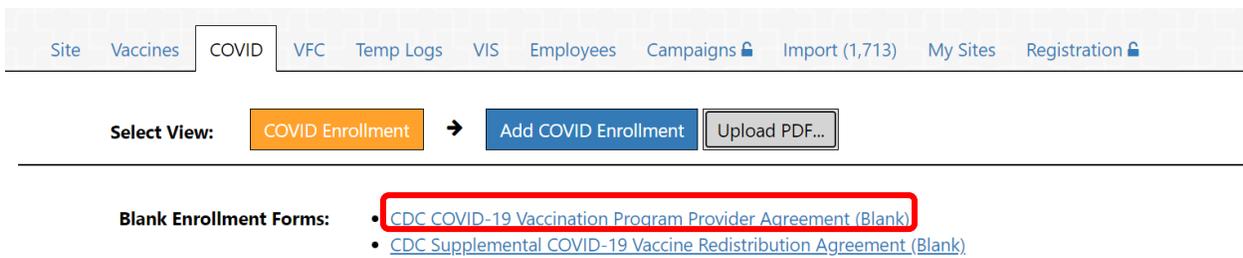
3. From this screen you have 2 options:

- Option 1: Upload PDF (box outlined in green below): With this option, you can upload the completed CDC COVID-19 Program Provider Agreement and it will populate the enrollment fields in I-CARE (instruction start on pg. 2)
- Option 2: Add COVID Enrollment (box outlined in orange below): With this option, you can enter the enrollment form fields directly into I-CARE (instructions start on pg. 4)

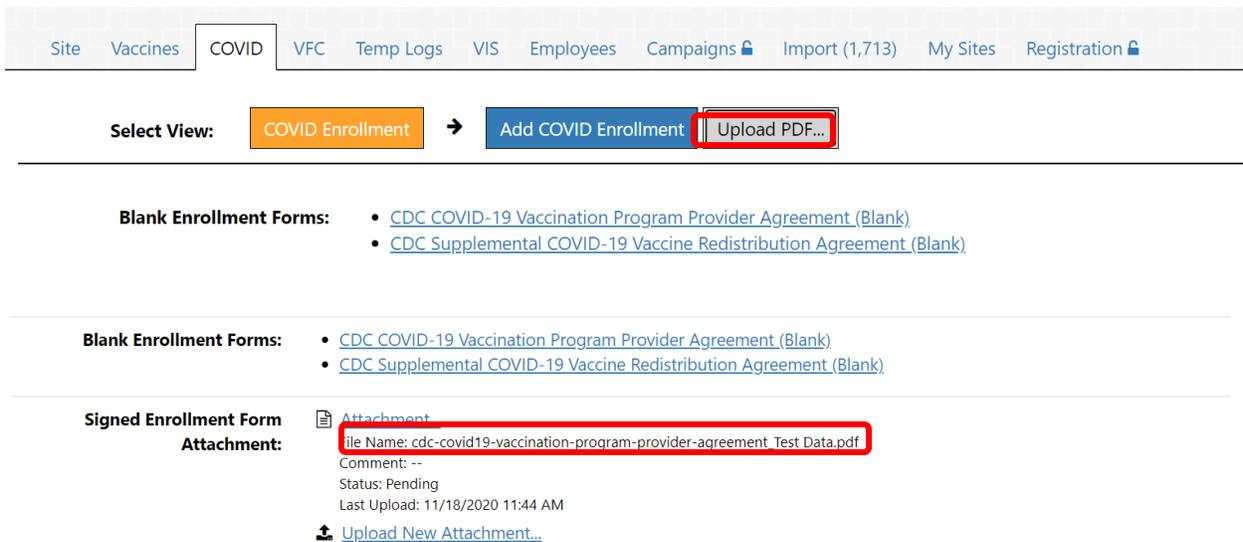


OPTION 1: UPLOAD PDF

1. Access the blank CDC COVID-19 Vaccination Program Provider Agreement. **You must complete the fillable form electronically for the data to transfer in I-CARE.** Complete the entire form, including capturing all electronic signatures from the CMO, CEO and medical direct/pharmacist/vaccine coordinator. Note: While the CMO and CEO information needs to be included on each form, they only need to sign one form for all sites covered under the healthcare system.



2. When the PDF form is completed, click the upload PDF button. The fields from the completed PDF will populate the fields in I-CARE and the PDF file will be added as an attachment.



3. It is important to double check all the fields from the PDF were correctly added to I-CARE, you can click Edit COVID enrollment to view and make any changes directly in I-CARE.



- When you are ready to submit, at the bottom of the screen, select **Change Status**, set the status to **Requested** and write any comments or questions you may have for CDPH.

Select an Action:

Enroll Status Date: 11/16/2020 11:18 AM
Enroll Status: Draft
New Status:

Add Comment:

Your name and the current date/time will be automatically included

- Select **Save** at the bottom of the screen.

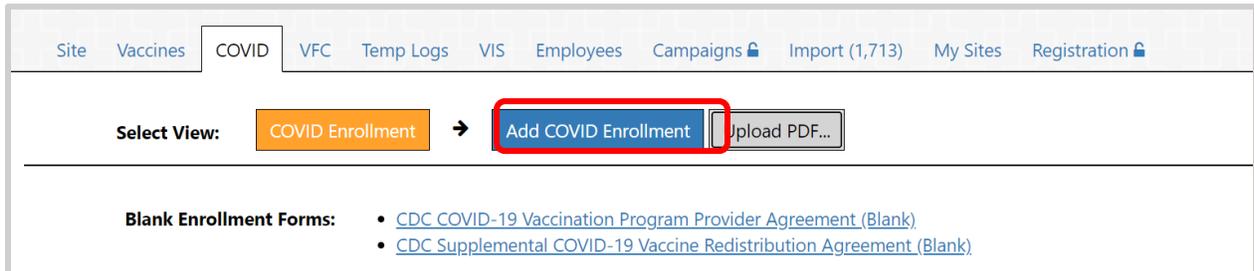
Select an Action:

If you exit and return to the COVID tab, scroll back to the top of the page and select **Edit COVID Enrollment** to continue

Select View: →

OPTION 2: ADD COVID ENROLLMENT

If you wish to manually input the enrollment form fields into I-CARE, you can select **Add COVID Enrollment** instead of uploading the completed PDF.



The screenshot shows the I-CARE interface with a navigation bar at the top containing links for Site, Vaccines, COVID, VFC, Temp Logs, VIS, Employees, Campaigns, Import (1,713), My Sites, and Registration. Below the navigation bar, there is a 'Select View:' section with three buttons: 'COVID Enrollment' (orange), 'Add COVID Enrollment' (blue, highlighted with a red box), and 'Upload PDF...' (grey). Below this section, there is a 'Blank Enrollment Forms:' section with two links: 'CDC COVID-19 Vaccination Program Provider Agreement (Blank)' and 'CDC Supplemental COVID-19 Vaccine Redistribution Agreement (Blank)'.

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

1. Complete the Organization Identification section for the main organization
 - a. *Take care as some fields auto-populate with site specific I-CARE data and may need to be changed manually to represent the parent organization information.*
2. Complete the Section for Responsible Officers
 - a. Complete CMO Information Section
 - b. Complete CEO Information Section
3. Thoroughly read the Agreement Requirements
 - a. Provide CMO Signature date
 - b. Provide CEO Signature date
 - c. *Enrollment form will need to be printed and signed upon completion of the form, and then uploaded into I-CARE. Instructions for this process will follow at the end of the guide.*

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

Section B needs to be completed for all vaccinating sites. Take care as some fields auto-populate with site specific I-CARE data and may need to be changed manually to represent the accurate information for COVID-19 vaccine.

1. Complete the following unique location identification information:
 - a. Location Name
 - b. Primary Vaccine Coordinator Information
 - c. Back-up Vaccine Coordinator Information
 - d. Vaccine Shipment Information
 - e. Vaccine administration Information (if different from receiving location)

2. Enter the **Days** and **Times** that vaccine coordinators are available for receipt of the COVID-19 vaccine
 - a. All times should be entered using a 24-hr. time range format
 - b. e.g. XX:XX - XX:XX. Please reference the example here.

Days and times vaccine coordinators are available for receipt of COVID-19 vaccine shipments

Use 24-hour time notation for time entries (i.e. 8:00 AM = 08:00, 1:15 PM = 13:15, 5:00 PM = 17:00).

	Monday	Tuesday	Wednesday	Thursday	Friday
AM:	<input type="text" value="09:00-11:59"/>				
PM:	<input type="text" value="12:00-16:00"/>				

3. Select the type of provider from the drop-down menu. (e.g. we have selected public health provider – public health clinic in the image below)

COVID-19 vaccination provider type for this location (select one)

Select Location Type:

Public health provider - public health clinic

- 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
- Home health care provider
- Hospital
- Indian Health Service
- Tribal health
- Medical practice - family medicine
- Medical practice - pediatrics
- Medical practice - internal medicine
- Medical practice - OB/GYN
- Medical practice - other specialty
- Pharmacy - chain
- Pharmacy - independent
- Public health provider - public health clinic
- Public health provider - Federally Qualified Health Center
- Public health provider - Rural Health Clinic
- Long-term care - nursing home, skilled nursing facility, federally certified
- Long-term care - nursing home, skilled nursing facility, non-federally certified
- Long-term care - assisted living
- Long-term care - intellectual or developmental disability
- Long-term care - combination (e.g., assisted living and nursing home in same facility)
- Urgent care
- Other (Specify):

4. Select the type of setting(s) where this location will be administering vaccine (see example below).
- a. Select all that apply

Setting(s) where this location will administer COVID-19 vaccine (select all that apply)

Select Location Settings:

- | | |
|-----------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Child care or day care facility | <input type="checkbox"/> Pharmacy |
| <input checked="" type="checkbox"/> College, technical school, or university | <input checked="" type="checkbox"/> Public health clinic (e.g., local health department) |
| <input checked="" type="checkbox"/> Community center | <input checked="" type="checkbox"/> School (K - grade 12) |
| <input type="checkbox"/> Correctional/detention facility | <input checked="" type="checkbox"/> Shelter |
| <input type="checkbox"/> Health care provider office, health center, medical practice, or outpatient clinic | <input checked="" type="checkbox"/> Temporary or off-site vaccination clinic - point of dispensing (POD) |
| <input type="checkbox"/> Hospital (i.e., inpatient facility) | <input checked="" type="checkbox"/> Temporary location - mobile clinic |
| <input type="checkbox"/> In home | <input type="checkbox"/> Urgent care facility |
| <input type="checkbox"/> Long-term care facility (e.g., nursing home, assisted living, independent living, skilled nursing) | <input checked="" type="checkbox"/> Workplace |
| | <input type="checkbox"/> Other (Specify): |

5. Complete patient information data for the number of patients seen annually (see example below)

Approximate number of patients/clients routinely served by this location

Number of children 18 years of age and younger:

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

Number of adults 19 - 64 years of age:

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

Number of adults 65 years of age and older:

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

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

 Unknown *
(Enter "0" if the location does not serve this age group.)
 Not applicable (e.g., for commercial vaccination service providers)

6. Provide the total number of flu vaccinations given during your peak week of flu vaccination last year.

Influenza vaccination capacity for this location

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

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



7. Select which populations are currently served by your practice (see example below).
- a. Select all that apply

Population(s) served by this location (select all that apply)

- Select Population:**
- General pediatric population
 - General adult population
 - Adults 65 years of age and older
 - Long-term care facility residents (nursing home, assisted living, or independent living facility)
 - Health care workers
 - Critical infrastructure/essential workers (e.g., education, law enforcement, food/agricultural workers, fire services)
 - Military - active duty/reserves
 - Military - veteran
 - People experiencing homelessness
 - Pregnant women
 - Racial and ethnic minority groups
 - Tribal communities
 - People who are incarcerated/detained
 - People living in rural communities
 - People who are underinsured or uninsured
 - People with disabilities
 - People with underlying medical conditions that are risk factors for severe COVID-19 illness
 - Other people at higher risk for COVID-19 (Specify)

8. Indicate whether your practice is currently reporting to I-CARE
- a. If yes, I-CARE is auto-populated
- b. If no or not applicable, please explain your planned method for reporting your vaccination administration information, or why these does not apply.

Does your organization currently report vaccine administration data to the state, local, or territorial immunization information system (IIS)?

If YES: List IIS Identifier:

If NOT:
Please explain planned method for reporting vaccine administration data to the jurisdiction's IIS or other designated system as required

If NOT APPLICABLE:
Please explain

9. Please enter your locations capacity to store additional 10 dose multidose vials during peak vaccination periods.
- a. Enter a number for each field where you have the capacity to store additional vaccine
- b. Select No capacity if you do not have capacity for that temperature. (i.e. no ultra-cold freezer)

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:

- Refrigerated (2°C to 8°C):** No capacity **OR** Approximately additional 10-dose MDVs *
- Frozen (-15°C to -25°C):** No capacity **OR** Approximately additional 10-dose MDVs *
- Ultra-frozen (-60°C to -80°C):** No capacity **OR** Approximately additional 10-dose MDVs *

10. List the Brand/Make/Model of your vaccine storage units (freezer/Fridge/Ultra-Cold Freezer).

Storage unit details for this location

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

- 1:
- 2:
- 3:
- 4:
- 5:

11. Provide the signature date of the Medical/pharmacy director or location's vaccine coordinator

- a. *Enrollment form will need to be printed and signed upon completion of the form, and then uploaded into I-CARE. Instructions for this process will follow at the end of the guide.*

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

Providers practicing at this facility

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

Provider Name	Title	License No.
<input type="text" value="DR. SAM MCTEST"/>	<input type="text" value="MEDICAL DIRECTOR"/>	<input type="text" value="036-123456"/>
<input type="text" value="DR. JULIE NOTREAL"/>	<input type="text" value="MEDICAL DIRECTOR"/>	<input type="text" value="036-987654"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

PRINT THE COMPLETED ENROLLMENT FORM, COLLECT SIGNATURES AND UPLOAD THE PDF WITH SIGNATURES

- 1. Once all fields have been completed select Save at the bottom of the screen.
 - a. This will return you to the COVID Enrollment Screen



- 2. Select "Print Enrollment" button



3. Have the appropriate staff sign the CDC Vaccination Program Provider Agreement in the following locations:
- Organization Medical Director (or equivalent)

Organization Medical Director (or equivalent)			
Last name:	First name:	Middle initial:	
Signature:		Date:	11/04/2020

- Chief Executive Officer (chief fiduciary role)

Chief Executive Officer (chief fiduciary role)			
Last name:	First name:	Middle initial:	
Signature:		Date:	11/04/2020

- Medical/pharmacy director or location's vaccine coordinator signature:

Storage unit details for this location	
List brand/model/type of storage units to be used for storing COVID-19 vaccine at this location:	I attest that each unit listed will maintain the appropriate temperature range indicated above (please sign and date):
1. THERMO SCIENTIFIC TSX SERIES REFRIGERATOR	Medical/pharmacy director or location's vaccine coordinator signature: Date: 11/12/2020
2. THERMO SCIENTIFIC REFRIGERATOR	
3. NORLAKE REFRIGERATOR	
4. REVCO REFRIGERATOR	
5. NORLAKE FREEZER	

4. Once all sections are signed, scan the form, and save it as a PDF. Next return to the COVID-19 Enrollment Screen and select Upload New Attachment

- Blank Enrollment Forms:**
- [CDC COVID-19 Vaccination Program Provider Agreement \(Blank\)](#)
 - [CDC Supplemental COVID-19 Vaccine Redistribution Agreement \(Blank\)](#)

Signed Enrollment Form Attachment: [Upload New Attachment...](#)

- Navigate to the file location where the file was saved.
- Select the file and click Open

5. Once the signed enrollment form is uploaded at the bottom of the screen select Change Status

Select an Action:

- a. Set New Status to **Requested** and add any comments you wish to include.

Enroll Status Date: 11/16/2020 11:18 AM
Enroll Status: Draft
New Status:
Add Comment:
Your name and the current date/time will be automatically included

- b. Select **Save** at the bottom of the screen.

Select an Action:

CONTACT US

If you have any questions or need any assistance please do not hesitate to contact the CDPH Immunization Program at COVID19Vaccine@cityofchicago.org