

PRACTICE PROFILE

All health care providers participating in a Public Vaccine Program must complete this form annually or more frequently if the number of patients served changes or the status of the facility changes during the calendar year.

Instructions: *Adobe Reader is required.* Download, save, and close the form prior to entering information. Locate and re-open the form. Complete all required fields and then re-save it. Email the form as an attachment to wdh-vfcreporting@wyo.gov.

***Scroll over highlighted text in the document for additional information and definitions.**

Today's Date:					
VACCINE PROGRAMS					
Please check the box next to the Public Vaccine Program(s) in which you intend to enroll:					
Vaccines for Children (VFC) Program			Wyoming Vaccinates Important People (WyVIP) Program		
Vaccines for Uninsured Adults (VUA) Program			Adult Hepatitis Vaccine (AHV) Program		
FACILITY INFORMATION					
Organization:					
Facility Name:					PIN:
Mailing Address:			City:	Zip:	
Delivery Address:			City:	Zip:	
Phone:			Fax:		
Facility Type: Public Private					
WyIR User Type:					
VACCINE DELIVERY <i>Please specify the hours that your facility is able to receive vaccine shipments.</i>					
	Monday	Tuesday	Wednesday	Thursday	Friday
	Time Open				
Lunch	Time Closed				
	Time Open				
	Time Closed				
<ul style="list-style-type: none"> Note: Offices must be open to receive vaccine at least 4 consecutive hours, at least 1 day per week other than Monday 					
VACCINE CONTACT INFORMATION <i>*Each facility must identify two (2) Vaccine Coordinators</i>					
RESPONSIBLE PHYSICIAN/PRACTITIONER:					
Title:		License Type:		License #:	
Email Address:					
Vaccine Coordinator (1):				Phone:	
Title/Credentials:			Email:		
Vaccine Coordinator (2):				Phone:	
Title/Credentials:			Email:		
Does anyone else other than the Responsible Physician/Practitioner need to sign the Provider Agreement?					NO
Name:			Title:		

PEDIATRIC VACCINES OFFERED

NOT APPLICABLE

All ACIP-Recommended Vaccines for Children 0 through 18 years of Age

Offers Select Vaccines (*This option is only available for facilities designated as Specialty Providers by the Immunization Program*)

Select all Pediatric Vaccines Offered by Specialty Provider:

DTaP	Influenza	Polio	Other, specify:
Hepatitis A	Meningococcal Conjugate	Rotavirus	_____
Hepatitis B	MMR	TD	_____
HIB	Pneumococcal Conjugate	Tdap	
HPV	Pneumococcal Polysaccharide		

PROVIDER POPULATION

***ALL APPLICABLE FIELDS ARE REQUIRED**

Provider Population based on patients seen during the previous 12 months.

Report the number of patients who received vaccinations at your facility, by age group. Only count a patient once based on the status at the last immunization visit, regardless of the number of visits made. The following table documents how many patients received publicly-supplied vaccine, by category, and how many received private vaccine

PEDIATRIC POPULATION

*Enter "0" if no pediatric population

VFC Vaccine Eligibility Categories	# of children who received VFC Vaccine by Age Category				
	<1 Year	1-2 Years	3-6 Years	7-18 Years	Total
Enrolled in Medicaid					
No Health Insurance					
American Indian/Alaskan Native					
Underinsured at FQHC/RHC or deputized facility ¹					
Total VFC:					
Non-VFC Vaccine Eligibility Categories	# of children who received non-VFC Vaccine by Age Category				
	<1 Year	1-2 Years	3-6 Years	7-18 Years	Total
Health Insurance (Wyoming residents/WyVIP-eligible)					
Health Insurance (NOT Wyoming residents)					
Other Underinsured ²					
Children's Health Insurance Program (CHIP)					
Total Non-VFC:					
TOAL PATIENTS: (must equal sum of Total VFC + Total Non-VFC)					

ADULT PATIENT POPULATION (19 and older)

Enrolled in Medicaid or Medicare:	No Health Insurance:	Health Insurance:
TYPE OF DATA USED TO DETERMINE PROVIDER POPULATION		<i>(choose all that apply)</i>
Benchmarking	Doses Administered	Other (must describe):
Medicaid Claims	Provider Encounter Data	_____
WyIR	Billing System	

Type name of person completing this form:	Date:
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