New Jersey Department of Health and Senior Services
Vaccine Preventable Disease Program
P.O. Box 369
Trenton, NJ 08625-0369

CHILDHOOD IMMUNIZATION GRANT-VACCINES
VACCINES FOR CHILDREN PROGRAM

PROVIDER PROFILE: ADULTS

All public and private health care providers approved by the State for participation in the Vaccines for Children Program (VFC) must complete this form. This document provides shipping information and helps the State determine the amount of vaccine to be supplied through the NJ VFC Program. The form also may be used to compare projected vaccine needs with actual vaccine supply. The New Jersey Vaccine for Children Program will keep this record on file with the "Provider Enrollment" form. The Provider Profile form must be updated annually or more frequently if: (1) estimates of adults served changes, or (2) the status of the facility changes. The form is to be completed for each provider site location and this form may be completed by one provider for the entire practice.

A. National Provider Identifier (NPI) | NJVFC Provider ID Number (PIN):

B. Name of Facility

C. Name of Contact Person (Last, First, MI)

D. Vaccine Delivery Address **(NO PO BOXES)**

Street Address: ______________________________

City, State, Zip: ______________________________ County: ______________

Office Hours (Days/Hours)

Telephone Number	Fax Number	Email Address
( )	( )	

E. Names of Other Physicians at the provider site who will also administer vaccines as VFC Program participants:
(Please fill out IMM-26A form attached.):

F. Type of Facility (Check Only One):

- 10 ☐ Public Health Department
- 25 ☐ Federally Qualified Health Center (FQHC)
- ☐ Planned Parenthood
- ☐ STD Clinic
- ☐ Drug Treatment Center
- ☐ Adult Clinic
- ☐ Adolescent Clinic
- ☐ Refugee Clinic
- ☐ Migrant Farm Worker Clinic

NOTE: The following information must be based on data and not estimates. Please document the data source for this information in the boxes provided in Section I.

G. For a 12-month period, project the **total number of adults** who will receive vaccinations at your practice/clinic:	11-18 Yrs.	19-29 Yrs.	30-39 Yrs.	40-59 Yrs.	60+ Yrs.	Total
	______	______	______	______	______	______

H. Of the total numbers entered in Section G, estimate how many are expected to be VFC eligible because they are:

(Note: Do not count an adolescent/adult twice or in more than one of the categories listed below):

	11-18 Yrs.	19-29 Yrs.	30-39 Yrs.	40-59 Yrs.	60+ Yrs.	Total
Enrolled in Medicare/Medicaid	______	______	______	______	______	______
Uninsured	______	______	______	______	______	______
317 *(Only available to local health departments)*	______	______	______	______	______	______
TOTALS (For Section "H" Only):	______	______	______	______	______	______

I. Type of data used to determine projected number of adults served in Section G and Section H:

- A ☐ Doses Administered Data
- B ☐ Medicaid Claims Data
- C ☐ Provider Encounter Data
- D ☐ Registry Data
- E ☐ Other (Specify): ______________________________

J. In case of a power failure, is a back-up generator on site?
☐ Yes ☐ No If Yes, submit form.

Is there a back-up plan for storage of vaccines?
☐ Yes ☐ No If Yes, submit form.

Signature	Date

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