KANSAS UNIVERSAL HEPATITIS B PROGRAM
MEMORANDUM OF UNDERSTANDING

In active pursuit of raising immunization rates of all children in the State, the Kansas Department of Health and Environment, Bureau of Epidemiology and Disease Prevention, Immunization Program, located at 1000 SW Jackson, Suite 210, Topeka, Kansas 66612-1290 and the Universal Hepatitis B Program, housed at

_____

Health Department

and

_____

Hospital

have recognized the need to provide effective, cost efficient and barrier free immunization services to the residents of Kansas and any and all others designated as clients and/or patients. Furthermore, all parties agree and acknowledge that the effectiveness of such services as provided by each organization will be augmented by and through cooperation, coordination, and communication of vaccine-related issues. Consequently, the Universal Hepatitis B Program and the Kansas Immunization Program are resolved to coordinate the administration of State and Federally provided vaccine.

Accordingly, the Universal Hepatitis B Program will establish immunization practices under the auspices of and in coordination with the Immunization Program. The Universal Hepatitis B Program began in Kansas on October 1, 1994 and is currently an ongoing, permanent component of the Kansas Immunization Program.

The responsibilities for the implementation of the Universal Hepatitis B Program will be as follows:

THE KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT, BUREAU OF EPIDEMIOLOGY AND DISEASE PREVENTION, IMMUNIZATION PROGRAM WILL:

A. Provide and distribute State and Federal hepatitis B vaccine to the

_____.
Health Department

B. Treat the Universal Hepatitis B Program in the same regard (such as reporting of doses administered and periodic audits) as in other immunization practices so that true evaluations of services can be made.

C. Provide Immunization Field Staff to orient and guide with required reporting.

D. Provide all vaccines free of charge.

E. Provide current Vaccine Information Statements (VIS).

F. Provide consultation on any vaccine issues which may arise.

G. Furnish vaccines as provided by Federal Vaccine Contracts.

_____ **WILL:**

Health Department

A. Provide hepatitis B immunization services to all children born on or after January 1, 1991.

B. Distribute hepatitis B vaccine to

_____

Hospital

received from the State/Federal funded supply.

C. Follow the *Standards for Pediatric Immunization Practices* published by the American Academy of Pediatrics (AAP) when providing immunization services; i.e., "open door" immunization service hours and immunization without physical examination.

D. Administer all immunizations in accordance with the Advisory Committee on Immunization Practices (ACIP) recommendations.

E. Use valid contraindications for all vaccines.

F. Submit monthly doses administered reports by the 10th of each month. Vaccine Request forms will be submitted with an anticipated 2-3 month supply request, provided adequate storage space is available.

G. Guarantee that all patients or their guardians have been given a copy and have read or explained to them the information about hepatitis B vaccine, and they have had the opportunity to ask questions and receive answers to their satisfaction and are aware of the benefits and risks. The publication date of the Vaccine Information Statement (VIS) provided to the patient or guardian must also be documented on the vaccine consent form.

H. Not file an SRS reimbursement claim on all children who receive vaccine from the State/Federal supply.

_____ **WILL:**
Hospital

A. Provide hepatitis B immunization services to all infants.

B. Administer all immunizations in accordance with the Advisory Committee on Immunization Practices (ACIP) recommendations.

C. Any administration fee charged for vaccine shall not exceed $14.88 per dose.

D. Use valid contraindications for all vaccines.

E. Not deny any child State/Federal funded vaccine for failure to pay an administration fee.

F. Submit monthly doses administered reports by the 5th of each month to the

_____.
Health Department

Vaccine request forms shall be submitted with an anticipated 2 month supply request, provided adequate storage space is available.

G. Guarantee that all patients or their guardians have been given a copy and have read, or have had explained to them, the information of the hepatitis B vaccine, and that they have had the opportunity to ask questions and receive answers to their satisfaction and that they are aware of the benefits and the risks for each immunization given, each time of administration.

H. Submit names, addresses, and phone numbers of all children who began the hepatitis B series at
_____ to the
Hospital

_____ by the 5th of each month
Health Department
for tracking purposes.

I. Not file an SRS reimbursement claim on children who receive State/Federal supplied vaccine.

J. Document the following information in the patient's permanent medical record:

1. Notation that receipt and discussion of the Vaccine Information Statement (VIS) was provided to the infant's parent/guardian. Publication date of the VIS given to the parent/guardian must also be documented in the medical record.

2. Date vaccine was administered to the infant.

3. Manufacturer and lot number of the vaccine given to the infant.

4. Name and address of the health care provider/institution administering the vaccine.

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MEMORANDUM OF UNDERSTANDING
Signature Page

_____Date_____
Health Department Representative Signature

Representative: _____

Health _____

Department: _____

Address: _____

_____

City, State, Zip: _____

Phone & Fax:

_____Date_____
_
Hospital Representative Signature

Representative: _____

Hospital: _____

Address: _____

_____

City, State, Zip: _____

Phone & Fax: _____

_____Date_____
_
Kansas Hepatitis B Coordinator

Jennifer M Hill, MPH, Epidemiologist/Hepatitis B Coordinator
Kansas Department of Health and Environment, Immunization Program
1000 SW Jackson, Suite 210
Topeka, KS 66612
(785)296-8156 Fax: (785) 291-3775

Signature Page (Continued)
Additional Signatures, if needed

_____Date_____
_

Representative: _____

Agency: _____

Address: _____

_____

City, State, Zip: _____

Phone & Fax: _____

_____Date_____
_

Representative: _____

Agency: _____

Address: _____

_____

City, State, Zip: _____

Phone & Fax: _____

HOSPITAL CONTACT INFORMATION

Please type or print the following inforamtion.

COUNTY	
COUNTY CONTACT	
HOSPITAL NAME	
ADDRESS	
TELEPHONE	
FAX	
HOSPITAL CONTACT PERSON	
VACCINE TO BE DELIVERED TO	
PHARMACY CONTACT PERSON	
PHARMACY PHONE NUMBER	
NURSERY CONTACT PERSON	
NURSERY PHONE NUMBERS	