ASIIS Enrollment Application

IRMS:

DIRECTIONS: Please complete and submit this form to ASIISHelpDesk@azdhs.gov

Organization Name: ____

Physical Address: ____

City: ______________________________ State:_____ Zip: _______ County_______________

Phone #: (_____)__________________________ FAX #: (_____) ______________________________

Organization Main Contact: ____

E-mail address: ____

Mailing Address: ____

City: _____________________________ State:_____ Zip: _________ County_______________

Please report all facility information on page 2.

Type of Organization:
(**Select only one)**

Family or General Practice
Pediatrics Practice
Family Health Center
School-Based Clinic or Family Resource and Wellness Center
Indian Health Service Unit (IHS/Tribal Health Center)
County Health Department
Private Hospital
Public Hospital
Community Health Center (FQHC)
Rural Health Center (RHC)
Other (please specify)_____________________________

Please contact ASIISHelpDesk@azdhs.gov if you have any questions.

Facility #1
Name: ____
Physical Address: ______________________________________
City: ____________________ State:____ Zip: ______ County____________
Phone #: (_____)____________________ FAX #: (_____) __________________
Facility Contact: _______________________________________
E-mail address: ____

Mailing Address: _______________________________________
City: ____________________ State:____ Zip: _______ County___________

Facility #2
Name: ____
Physical Address: ______________________________________
City: ____________________ State:____ Zip: ______ County____________
Phone #: (_____)____________________ FAX #: (_____) __________________
Facility Contact: _______________________________________
E-mail address: ____

Mailing Address: _______________________________________
City: ____________________ State:____ Zip: _______ County___________

Facility #3
Name: ____
Physical Address: ______________________________________
City: ____________________ State:____ Zip: ______ County____________
Phone #: (_____)____________________ FAX #: (_____) __________________
Facility Contact: _______________________________________
E-mail address: ____

Mailing Address: _______________________________________
City: ____________________ State:____ Zip: _______ County___________

Facility #4
Name: ____
Physical Address: ______________________________________
City: ____________________State:____ Zip: ______ County____________
Phone #: (_____)____________________ FAX #: (_____) __________________
Facility Contact: _______________________________________
E-mail address: ____

Mailing Address: _______________________________________
City: ____________________ State:____ Zip: _______ County___________

ADHS

IRMS:

Arizona State Immunization Information System (ASIIS) User Information

Organization Name: ____

Facility Name: ____

The following methods will be used to report immunization information to the ASIIS Registry:

Web Application (Direct access to the registry via the Internet)
Electronic Medical Record (EMR) via HL7 v2.5.1

Name of PMS/EMR: ____________________ Name of Vendor: ______________________

Please list the full name, email and select a user privilege for each staff members who will use the web application.

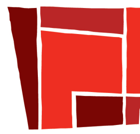
- View Privilege means you can only look at the patient record and immunization record.
- Edit Privilege means you can view, add and make changes to patient and immunization record.

Name	Email Address	Privilege
		View Edit
		View Edit
		View Edit
		View Edit
		View Edit
		View Edit
		View Edit
		View Edit

All Users shall electronically accept the terms of the Pledge to Protect Confidential Information on their first login.

Please contact ASIISHelpDesk@azdhs.gov if you have any questions.

ASIIS is a computer based immunization registry and tracking system implemented by the Arizona Department of Health Services and its partners. It is intended to aid health care professionals and other users who have a need to check a client's immunization status according to A.R.S § 36-135, R9-6-707, and R9-6-708. Through ASIIS, providers can place orders for publicly funded vaccines to provide to children eligible to receive VFC vaccines. Client-specific information and vaccine ordering privileges are only available to authorized users and the Arizona Department of Health Services. The Users enters into this agreement with the Arizona Department of Health Services and agree to adhere to all requirements that are listed in the Pledge to Protect Confidential Information.



Interoperability:
Provider EHR and ASIIS Electronic Data Exchange
Initial Interest Form

Please complete pages 1 and 2 of this form (to the best of your ability) to indicate your interest in participation with the ADHS interoperability project. Fax or email as directed below.

A. Provider Organization

Organization Name:				
ASIIS IRMS Id:				
Street Address:				
City:				
State:				
Zip code:				
Phone/Fax:	Phone:		Fax:	
Number of Providers	# of MDs:	#of DOs:	# of NPs:	# of PAs:
Patient Descriptors	# of Children:	# of Adults:	% of Patients on AHCCCS: %	

B. Electronic Health Record System (EHR)

EHR Name:	
EHR Vendor:	
Software version:	
Years in use:	

C. Data Exchange

What version of HL7 can your EHR system produce (ask your vendor)?

________ HL7 2.3.1

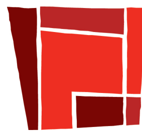
________ HL7 2.5.1

Preferred Transport Mechanism (ask your vendor)

________ Web Service

________ HTTPS POST

________ Other, please specify ____



D. Office Contact

Primary Office Contact

Name:	
Email:	
Phone number:	

Primary Technical Contact

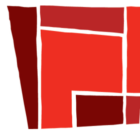
Name:	
Email:	
Phone number:	

Secondary Technical Contact

Name:	
Email:	
Phone number:	

Other Contacts

Possible Project Team	Personnel Name	Telephone Number	Email
IT Support			
Primary Decision Maker			
Project Manager			
Business Operations			



ARIZONA DEPARTMENT OF HEALTH SERVICES
PREPAREDNESS

Interoperability:

Provider Electronic Health Record system and ASIIS Electronic Data Exchange

<u>Provider Readiness Checklist:</u>

Complete this check list to see if your practice is ready to start working with ADHS on direct submission from your Electronic Health Record to ASIIS.

1) We have been using our current Electronic Health Record (EHR) system for at least 6 months.
2) We have a high speed internet connection and are able to connect to ASIIS via our EHR.
3) Our EHR has been certified by the Certification Commission for Healthcare Information Technology (CCHIT). If you don't know, please ask your EHR vendor.
4) Our EHR sends and receives electronic data using HL7 messages version 2.5.1. If you don't know, please ask your EHR vendor.
5) Our EHR vendor has a history of supporting our office when we need technical assistance with their product.
6) We have access to Information Technology (IT) support when we need it. This support has the capacity to understand, translate and correct HL7 message protocol errors. If you don't know, ask your IT support provider or EHR vendor.
7) We want to reduce our staff time required to report to ASIIS.
8) We want complete, accurate immunization records on all of our patients.
9) We want to reduce vaccine wastage by eliminating unnecessary vaccinations.
10) Our practice is committed to quality data exchange with ASIIS and will provide the staff time and effort necessary to develop, test and implement an interface with ASIIS.

Once this form is completed, please fax or email it to

ASIIS Interoperability Team

Fax: 602-364-3285

Email: ASIIS_Group1@azdhs.gov