2019 TB and STD Medication Facility Profile

Completed forms should be EMAILED to: DPH.TB-STDDRUGS@ct.gov

All public and private health care providers who receive medication from the Department of Public Health (DPH) Tuberculosis (TB) and Sexually Transmitted Diseases (STD) Programs must complete this form. This document provides shipping information and helps to determine the amount of medications that will be needed. The form is also used to compare estimated medication needs with actual medication supply. The Facility Profile form must be updated annually or if: (1) the facility address changes; (2) the facility closes; or (3) there is a change in Provider. **Complete one Provider Profile for each office, site and satellite.**

Federal Employer Tax ID ____ ____ ------ ____ ____ ____ ____ ____ ____ ____	**Please Check One** Re-Enrolling ☐ New Provider ☐	**Date**

FACILITY INFORMATION

Facility Name:			Check all that apply: TB ☐ STD ☐
Facility Address:			
City:		State:	Zip:
Telephone:		Fax:	
Shipping Address (*if different than facility address):*			
City:	County:	State:	Zip:

PRIMARY CONTACT

Instructions: *The primary contact is the person at this facility who has primary responsibility for ordering, monitoring, and ensuring the appropriate oversight of medications at the facility; the back-up contact has responsibility in the primary contact's absence.*

Primary Contact Name:	
Telephone:	Email: (NOTE: this email address will receive TB-STD communications)
Back-Up Contact Name:	
Telephone:	Email: (NOTE: this email address will receive TB-STD communications)

Type of Facility (check one)

☐ Local Health Department	☐ TB Clinic
☐ Federally Qualified Health Center (FQHC) or Federally Funded Rural Health Clinic (RHC)	☐ Private Practice (Individual or Group)
☐ School Based Health Center	☐ Hospital Clinic
☐ STD Clinic	☐ Other (please specify)_____
☐ HIV Clinic	
☐ Drug Treatment Facility	
☐ Family Planning Clinic	

Patient Enrollment and Insurance Status All facilities must provide total patient enrollment numbers by age group (years) and insurance status in order to receive medication from DPH. New facilities can give an estimate.

	0-14	15-18	19-24	25-44	>45
1. Number of Privately Insured Patients					
2. Number of Medicaid Enrolled Patients (HUSKY A)					
3. Number of Patients Without Insurance					
4. Number of Underinsured Patients					
5. Number of Patients Treated for TB Disease annually					
6. Number of Patients Treated for LTBI annually					
7. Number of Patients Treated for STDs (chlamydia, gonorrhea, syphilis, Trichomonas, herpes) annually					

Data Source What data source was used to determine the data provided above:

☐ Billing System ☐ Electronic Health/Medical Records ☐ Other_____

PROVIDERS PRACTICING AT THIS FACILITY

Instructions: *List below all licensed health care providers (MD, DO, NP, PA, pharmacist) at your facility who have prescribing authority and will be using DPH provided medications. Add additional pages if needed.*

Provider Name	Title	License #	Medicaid #	NPI#