UTAH MEDICAID NURSING FACILITY
QUALITY IMPROVEMENT INCENTIVE (2)(xi)
APPLICATION Worker Immunization, Rule R414-504-4

This form and all supporting documentation must be emailed on or before May 31st of the incentive period.

Facility Name: _____

National Provider I.D. _____ Administrator: _____

Please mark all that are complete:

- ☐ This facility provided flu or pneumonia immunizations for its workers free of charge.
- ☐ A signature list of recipients is included.
- ☐ The vaccine was purchased by May 31st, of the incentive period.
- ☐ The vaccine was used between July 1st, and May 31st, of the incentive period.
- ☐ Proof of purchase that includes receipts and invoices, is also attached. This includes proof of payment, i.e. cancelled check(s), financial debt instrument, etc. Check amounts must match receipt and invoice amounts. If the check does not match the receipt or invoice amount, an itemized list of invoices paid by the check must be provided with one entry matching the amount of the receipt or invoice for which the facility is seeking incentive payments.

Qualifying facilities may receive up to $15 per Medicaid Certified bed under this incentive (count as of 7/1). This incentive is part of incentive (2). The maximum a facility may receive from all incentives in incentive (2) combined, is the amount posted on the website per Medicaid Certified bed (count as of 7/1).

Facilities will not receive more than was expended under this incentive.

Attach Spreadsheet for detail expenditures.

Vaccine	Number of Doses	Amount Per Dose*	Total (Doses X Amount Per Dose)
Flu		$	$ 0.00
Pneumonia		$	$ 0.00
		Grand Total:	$ 0.00

* Supporting documentation must confirm:
- the amount per dose,
- a list and count of the facility's workers receiving vaccinations (by vaccine), and
- the total amount requested for this application

Total Reimbursement Requested (should match spreadsheet): $_____

Please ensure that all the supporting documentation is included. Failure to include all of the above detailed information will prevent the facility from qualifying.

By submitting this application I certify that all of the above criteria have been met.

Administrator Signature: _____ Date: _____

Note: Division staff will not request additional information relating to this submission. Please be sure to include all necessary information in order to qualify.

Email to: qii@utah.gov