Readiness Assessment Questionnaire

*for the purposes of this form clinics and hospitals are both referred to as facilities.

1. What is the name of your organization?
   __________________________________________________________________________
   a. Office manager or Meaningful Use Coordinator _____________________________
   b. Phone number __________________
   c. Email _________________________________________________________________

2. Does your facility(s) participate in the Vaccines for Children (VFC) program? Yes / No
3. Who is your VFC Coordinator (if valid): ________________________________________
4. If your organization is not VFC do you maintain your private inventory in MIIX? Yes / No
5. Does the organization have more than one facility/location? Yes / No
   *If more than 1 facility will submit immunizations from the same server please answer yes and complete #6 for each location.

6. Please list all facilities, addresses, VFC PINs (if valid) and contact information for each.

<table>
<thead>
<tr>
<th>Clinic/Hospital name</th>
<th>Email address</th>
<th>VFC pin (if valid)</th>
<th>Clinic manager</th>
<th>Phone number</th>
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7. What is the name of your EHR vendor and the version of your EHR
   a. Name: ____________________________________________________________
   b. Version: ___________________________________________________________
8. How long has this version been in production in your facility? ________________
9. When do you plan to upgrade your EHR system? ______________________________
   To What version? ______________________________________________________
10. Please provide the contact information for your EHR provider.
    a. Name: ____________________________________________________________
    b. Email: ____________________________________________________________
    c. Phone: ____________________________________________________________
11. Who provides support for EHR software application? ___Local support or ___help
desk. If there is a primary contact, please provide contact information.
    a. Name: ____________________________________________________________
    b. Email: ____________________________________________________________
    c. Phone: ____________________________________________________________
12. What age patients are given immunizations in this facility? ____________________
13. Approximately how many immunizations are given at this facility per month? _______
14. What categories of vaccines are provided? _____VFC, ____ Private, or ____Both
15. Is your EHR currently 2014 certified?______________________________________
16. Does your facility intend to do bi-directional messaging? Yes / No / Unknown
17. What version of HL7 messaging is your EHR capable of transmitting? (2.3.1, 2.5.1 etc..)
18. Is your facility a birthing hospital? _________________________________________
19. Do you have a policy/process for updating a newborns name from Baby Boy / Baby Girl
to the name given by the parent(s) or guardian(s)? Yes / No

** Birthing Facilities Only **
This policy/process needs to be sent to the State with this form.