TEXAS Health and Human Services | Texas Department of State Health Services

Adult Safety Net (ASN) Program

ASN Compliance Site Visit Acknowledgement of Receipt

Provider Name: _____ PIN: _____

Site Reviewer: _____ Email: _____

Thank you for participating in this ASN Compliance Site Visit. Please take a few minutes to review your unmet items with your reviewer. The goal of this visit is to support you and your staff with successfully implementing the program and improving access to vaccines for ASN-eligible adults within your practice.

To close out today's visit, please complete the Provider Acknowledgement section of the form below and keep a copy of this document for your records. Thank you for your continued dedication to the ASN Program.

TO BE COMPLETED BY SITE REVIEWER

I, _____, acknowledge that an ASN Compliance Site Visit was performed today on
(Site Reviewer)
_____ and that I have provided a copy of the Standards for Adult Immunization Practice, developed by the
(Visit Date)
Centers for Disease Control & Prevention, and the Adult Immunization Schedule (if needed). A follow-up plan that includes any follow-up actions required (as applicable) and a list of all current ASN Program Requirements assessed during the visit will be provided by the Texas Department of State Health Services following the site visit.

TO BE COMPLETED BY PROVIDER

If the Medical Director (or equivalent) is present:

I, _____, acknowledge that my practice took part in the ASN Compliance Site
(Medical Director)
Visit noted above. I understand the findings of the visit and agree to take all required actions necessary to meet ASN Program Requirements (as applicable).

If the Medical Director (or equivalent) is NOT present:

I, _____, acknowledge that my practice took part in the ASN Compliance Site
(Responsible Individual designated by MD)
Visit noted above. I understand and will communicate to the Medical Director the findings of the visit and any required actions that must be taken by our office in order to meet ASN Program Requirements (as applicable).

Reviewer Signature: _____ Date: _____

Provider Signature: _____ Date: _____