PREVENTION MATTERS – Sign up by Oct. 11 for Oct. 19 flu shot!

Flu season has started already, so sign up for a FREE influenza vaccination by the Thursday, October 11 deadline by calling (302) 744-2310 and then roll up your sleeve on **Friday, October 19, 2018** from 8:30 – 11:30 A.M. during the Employee Health & Wellness Fair at the County Administrative Complex in Room 220; from 11:30 A.M. – 1:30 P.M. at the Emergency Services Building; and from 2:00 – 4:00 P.M. at the Kent County Regional Resource Recovery Facility.

The FREE flu clinic is being held in conjunction with the annual **Employee Health & Wellness Fair** featuring dozens of health related exhibitors, displays, and giveaways from 8:30 A.M. – 1:30 P.M. in Room 220 in the Kent County Administrative Complex.

CVS, who is administering the free vaccinations this year, is able to bill medical insurance for those employees/retirees who are enrolled with DVHT/Aetna at no direct cost to the County. Unfortunately, CVS is unable to invoice Tricare for those employees/retirees who are enrolled in a military medical insurance plan. Employees/retirees without County provided health insurance are encouraged to get the flu vaccination from their primary care physician or other approved provider. Kent County does not reimburse any applicable co-payments.

All eligible County influenza vaccination program participants are asked to bring a copy of their photo ID, medical insurance card, and if Medicare eligible, to bring a copy of their Medicare card as well to the desired site location on the day of the event (Oct. 19). To sign up for your vaccination (an accurate count is needed), please call Evelyn Jopp in the Personnel Office at 744-2310. In order to offer this vaccination program as a no-cost benefit to employees/retirees, there must be at least 24 vaccines administered at each location. Deadline to sign up is Thursday, October 11, 2018. Any site without a minimum 24 sign-ups will be canceled and interested health plan enrollees will need to get their flu shot at the Administrative Complex, which has already met the minimum participation requirement.

If you cannot attend one of the clinics, you may obtain your flu vaccine from your in-network health care provider. Your standard co-pay may apply for your

primary care provider to administer the vaccine if you are required to schedule an appointment to get the shot.

Protect yourselves, family, friends, and co-workers this winter season by getting a flu vaccine.

Still have questions? Contact the Personnel Office at (302) 744-2310.

(posted 10/02/18)

Kent County Levy Court DVHT/AETNA health plan enrollees

Protect Yourself and Those You Love...

DEADLINE for flu shot sign up is Thursday, **October 11** at (302) 744-2310

GET A FLU SHOT ON OCT 19!

1) Delaware Valley Health Trust/Aetna enrollees and their covered dependents can get a flu shot as easy as 1, 2, 3:
Kent County Levy Court On-Site Flu Clinics – Friday, October 19, 2018
8:30 AM – 11:30 AM @ Administrative Complex
11:30 AM - 1:30 PM @ Emergency Services Building*
2:00 PM - 4:00 PM @ Wastewater Treatment Facility*
Walk-in appointments. Spouses and dependents 9+ are eligible to participate. Bring your Aetna card to receive a free flu shot. ***Sign up by Oct. 11 at 744-2310***

2) Doctor's Office. Call your primary care physician to make an appointment today.

3) An Aetna participating retail or walk-in clinic. To find a provider, log onto Aetna.com and click "Find a Doctor", then "Find a Flu Shot/Vaccine Provider" under Procedures.

QUESTIONS? Call the Delaware Valley Health Trust at 267.803.5724 or email dvhtclaims@dvtrusts.com

DELAWARE VALLEY HEALTH TRUST

***Clinic Site must have 24+ sign ups or will be canceled**

Important: Flu shots are not covered if administered at urgent care centers or hospital emergency rooms.

DELAWARE VALLEY TRUSTS
Managed Risk. Collective Rewards.

719 DRESHER ROAD | HORSHAM, PA 19044-2205 | PHONE: (215) 706-0101 | FAX: (215) 706-0895 | WWW.DVTRUSTS.COM

/FluShot/DVHT

Store # _____ Address _____

RX # _____ City, State, Zip _____ Telephone _____

Inactive Vaccine Consent and Administration Record

Patient Information:

Last Name _____ First Name _____ Date of Birth _____

Address _____ City, State, Zip _____ Phone _____

Primary Care Provider (PCP) Name _____ PCP Phone # _____

PCP Address _____ City, State, Zip _____ PCP Fax # _____

Screening Questions:

	YES	NO	DON'T KNOW
1. Are you sick today? (For example: a cold, fever or acute illness)	☐	☐	☐
2. Do you have allergies or reactions to any foods, medications, vaccines or latex? (For example: eggs, gelatin, neomycin, thimerosal, etc.) List _____	☐	☐	☐
3. Do you take anticoagulation medication? (For example: warfarin, Coumadin or other blood thinner)	☐	☐	☐
4. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g. diabetes), anemia or other blood disorder?	☐	☐	☐
5. For women: Are you pregnant or nursing? Could you become pregnant during the next month?	☐	☐	☐

CONSENT FOR SERVICES: I have been provided with the Vaccine Information Sheet(s) corresponding to the vaccine(s) that I am receiving. I have read or have had explained to me the information provided about the vaccine I am to receive. I have had the chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of vaccination and I voluntarily assume full responsibility for any reactions that may result. I request that the vaccine be given to me or to the person named above for whom I am authorized to make this request.

AUTHORIZATION TO REQUEST PAYMENT: I do hereby authorize CVS Pharmacy® ("CVS®") to release information and request payment. I certify that the information given by me in applying for payment under Medicare or Medicaid is correct. I authorize release of all records to act on this request. I request that payment of authorized benefits be made on my behalf.

DISCLOSURE OF RECORDS: I understand that CVS® may be required to or may voluntarily disclose my health information to the physician responsible for this protocol of specific health information of people vaccinated at CVS (if applicable), my Primary Care Physician (if I have one), my insurance plan, health systems and hospitals, and/or state or federal registries, for purposes of treatment, payment or other health care operations (such as administration or quality assurance). I also understand that CVS will use and disclose my health information as set forth in the CVS Notice of Privacy Practices (copy is available in-store, online or by requesting a paper copy from the pharmacy).

X _____ **Date:** _____

Signature of patient to receive vaccine or person authorized to make the request (parent/guardian)

Vaccine Administration Information:

Administration Date _____ Vaccine _____ Manufacturer _____

Lot # _____ Exp. Date _____ Route _____ Site _____

Volume (mL) _____ VIS Version Date _____ Date VIS Given to Pt _____

_____ _____

Administering Immunizer Name & Title Administering Immunizer Signature