



HTA VAX Secure Invoice Upload

Tracking Number
500

Date
6/24/2021

Contract Information

Please enter the contract number first to automatically populate the fields listed with an asterisk (*) Please note that these fields are "Read Only" and edits are not permitted on the form.

| | | | |
|--|--|--------------------------------|--|
| HTA-VAX-148 Contract Number (required) | TIDELANDS HEALTH * Contractor Name | 02-0598440 * Tax ID | 7000285006 * SCEIS Number |
| Elizabeth S. Ward Contact (Full Name) | EVP & CFO Title | (843) 527-7102 Phone | elward@tidelandshealth.org Contact EMAIL |
| PO Box 421718 * Address | Georgetown * STE # | SC * State | 29442 * Zip |

| | |
|-----------------------|-----------------------|
| INVOICE NUMBER | INVOICE AMOUNT |
| 2 | 293,530.00 |

Please Upload Invoice for Payment Review

To ensure prompt processing of your invoice ensure that you include the invoice number in the file name that you upload. Please ensure that all required information is included on the invoice. Click below for more details

Secure Document Upload

Please upload the invoice PDF to our secure website using the buttons below.

COVID19_Vaccine_Reimbursement_Calculator GPVC

I certify that no other funds have been received or will be reimbursed by any other source for the amounts claimed on this invoice

Signature (required) Click to Sign

Elizabeth S. Ward
6/24/2021 6:05:18 PM

\$293,530.00
Invoice Total

Yes
 No

The attached invoice is accurate and the invoice total is correct.

ACC Testing Approval

Bonner, Melissa
6/25/2021 12:02:42 PM

Budget and Finance Approval

Samuels, Tierra B.
6/28/2021 7:02:23 PM

Approved Funding **\$996,649.00**

Approved Invoices to Date

Available Funding **\$996,649.00**

Payment Processing Instructions

Full Amount \$293,530.00 31070000 Not Relevant
 J0402AZ999 J040X01048580130 5021310000 98000018

Accounts Payable Approval

Robinson, Sharon D.
7/1/2021 9:17:50 AM



If rejecting this form for any reason please provide a brief note to the agency. It will be included in the rejection email notification

COVID-19 Vaccination Reimbursement Request

Community Vaccination Event Information*

| | |
|------------------------------|--|
| Provider Name: | Tidelands Health (Inv. 2) |
| COVID-19 Vaccine Pin Number: | SCA285399 |
| Location Name: | Tidelands Health@ Georgetown County Regional Vaccination Site |
| Location Address (incl zip): | 1610 Hawkins Street & 606 Blackriver Road Georgetown, SC 29440 |
| Date & Times: | See attached spreadsheet - January 18 - June 10, 2021 - ALL SELF PAY |
| Total # Vaccinations: | 25413 |
| Eligible Vaccinations**: | 1970 |

Please select yes or no to the following questions to determine eligible reimbursement:

| | |
|------------|---|
| <u>Yes</u> | Did your organization provide event management, traffic control and logistics for this event? |
| <u>Yes</u> | Did your organization provide administrative staff for this event? |
| <u>Yes</u> | Did you organization provide vaccination staff for this event? |

Reimbursement Calculator

| Item | Rate | Eligible Event Reimbursement |
|---|------|------------------------------|
| Event Mgmt, Traffic, Logistics | \$10 | \$254,130 |
| Administrative Staff | \$5 | \$9,850 |
| Vaccination Staff | \$15 | \$29,550 |
| Total Event Reimbursement Amount | | \$293,530 |

Additional Cost Summary***:

| | |
|-----------------------------------|------------|
| Total additional cost: | |
| Less other funding/reimbursement: | |
| Net additional cost: | \$0 |

Total Request Amount: \$293,530

* Community Vaccination Events may span multiple days as long as the event location remains the same. All dates should be specified.

** If seeking third-party reimbursement for the services at the event was not appropriate or feasible, then all vaccinations are eligible for reimbursement. If billing third party payers was feasible, then only vaccinations not eligible for insurance reimbursement are eligible for Staffing Reimbursement.

*** Claiming additional costs requires detailed justification and documentation. Please attach answers to the following questions:

- 1) Summary Description of Request and Costs
- 2) Describe Benefit to the State of South Carolina and Statewide Vaccination Efforts including the future distribution and administering of vaccines.
- 3) Describe activities conducted and outcomes expected or achieved
- 4) Is the cost being covered by any other funding source or insurance? Please explain.
- 5) Were all avenues of funding exhausted before using Vaccine Reserve Account funds? Please explain.

Invoice 2

| DATE | # of Self Pay Vaccines |
|--------|------------------------|
| 18-Jan | 3 |
| 19-Jan | 1 |
| 20-Jan | 3 |
| 21-Jan | 5 |
| 22-Jan | 4 |
| 25-Jan | 1 |
| 26-Jan | 5 |
| 27-Jan | 8 |
| 28-Jan | 16 |
| 29-Jan | 21 |
| 2-Feb | 2 |
| 3-Feb | 2 |
| 9-Feb | 16 |
| 11-Feb | 3 |
| 12-Feb | 1 |
| 15-Feb | 2 |
| 16-Feb | 7 |
| 17-Feb | 8 |
| 18-Feb | 2 |
| 19-Feb | 1 |
| 24-Feb | 1 |
| 3-Mar | 4 |
| 4-Mar | 3 |
| 5-Mar | 2 |
| 8-Mar | 28 |
| 9-Mar | 57 |
| 10-Mar | 32 |
| 11-Mar | 50 |
| 12-Mar | 75 |
| 16-Mar | 11 |
| 17-Mar | 66 |
| 18-Mar | 56 |
| 19-Mar | 58 |
| 20-Mar | 37 |
| 23-Mar | 49 |
| 24-Mar | 14 |
| 25-Mar | 23 |
| 26-Mar | 71 |
| 30-Mar | 35 |
| 31-Mar | 40 |
| 1-Apr | 71 |
| 2-Apr | 81 |
| 5-Apr | 34 |

| | |
|--------------------|-------------|
| 6-Apr | 43 |
| 7-Apr | 85 |
| 8-Apr | 90 |
| 9-Apr | 50 |
| 13-Apr | 39 |
| 14-Apr | 19 |
| 15-Apr | 62 |
| 16-Apr | 87 |
| 17-Apr | 28 |
| 20-Apr | 25 |
| 21-Apr | 31 |
| 22-Apr | 49 |
| 23-Apr | 24 |
| 29-Apr | 94 |
| 6-May | 92 |
| 13-May | 55 |
| 20-May | 24 |
| 27-May | 27 |
| 3-Jun | 29 |
| 10-Jun | 8 |
| <u>Grand Total</u> | <u>1970</u> |