Utah VFC
Utah Vaccines for Children

VFC PIN / USIIS ID

Vaccines for Children Program
Provider Agreement

FACILITY INFORMATION			
Facility Name:			
Facility Address:			
City:	County:	State:	Zip:
Telephone:		Fax:	
Shipping Address (*if different than facility address)*:			
City:	County:	State:	Zip:

MEDICAL DIRECTOR OR EQUIVALENT	
Instructions: *The official VFC registered health care provider signing the agreement must be a practitioner authorized to administer pediatric vaccines under state law who will also be held accountable for compliance by the entire organization and its VFC providers with the responsible conditions outlined in the provider enrollment agreement. The individual listed here must sign the provider agreement.*	
Last Name, First, MI:	Title:
Specialty:	License No.:
Medicaid or NPI No.:	Employer Identification Number:
Email:	

VFC VACCINE COORDINATOR	
Primary Vaccine Coordinator Name:	
Telephone:	Email:
Completed annual training: ❑ Yes ❑ No	Type of training received:
Back-Up Vaccine Coordinator Name:	
Telephone:	Email:
Completed annual training: ❑ Yes ❑ No	Type of training received:

PROVIDERS PRACTICING AT THIS FACILITY *(additional spaces for providers at end of form)*				
Instructions: *List below all licensed health care providers (MD, DO, NP, PA, pharmacist) at your facility who have prescribing authority and will authorize vaccine administration.*				
Provider Name	**Title**	**License No.**	**Medicaid or NPI No.**	**EIN (*Optional)***

PROVIDER AGREEMENT	
To receive publicly funded vaccines at no cost, I agree to the following conditions, on behalf of myself and all the practitioners, nurses, and others associated with the health care facility of which I am the medical director or practice administrator or equivalent:	
1.	I will annually submit a provider profile representing populations served by my practice/facility. I will submit more frequently if 1) the number of children served changes or 2) the status of the facility changes during the calendar year.
2.	I will screen patients and document eligibility status at each immunization encounter for VFC eligibility (i.e., federally or state vaccine-eligible) and administer VFC-purchased vaccine by such category only to children who are 18 years of age or younger who meet one or more of the following categories: A. Federally Vaccine-eligible Children (VFC eligible) 1. Are an American Indian or Alaska Native; 2. Are enrolled in Medicaid; 3. Have no health insurance; 4. Are underinsured: A child who has health insurance, but the coverage does not include vaccines; a child whose insurance covers only selected vaccines (VFC-eligible for non-covered vaccines only). Underinsured children are eligible to receive VFC vaccine only through a Federally Qualified Health Center (FQHC), or Rural Health Clinic (RHC) or under an approved deputization agreement. B. State Vaccine-eligible Children 1. In addition, to the extent that my state designates additional categories of children as "state vaccine-eligible", I will screen for such eligibility as listed in the addendum to this agreement and will administer state-funded doses (including 317 funded doses) to such children. Children aged 0 through 18 years that do not meet one or more of the eligibility federal vaccine categories (VFC eligible), are **not** eligible to receive VFC-purchased vaccine.
3.	For the vaccines identified and agreed upon in the provider profile, I will comply with immunization schedules, dosages, and contraindications that are established by the Advisory Committee on Immunization Practices (ACIP) and included in the VFC program unless: a) In the provider's medical judgment, and in accordance with accepted medical practice, the provider deems such compliance to be medically inappropriate for the child; b) The particular requirements contradict state law, including laws pertaining to religious and other exemptions.
4.	I will maintain all records related to the VFC program for a minimum of seven years as required by state law, and upon request make these records available for review. VFC records include, but are not limited to, VFC screening and eligibility documentation, billing records, medical records that verify receipt of vaccine, vaccine ordering records, and vaccine purchase and accountability records.
5.	I will immunize eligible children with publicly supplied vaccine at no charge to the patient for the vaccine.
6.	I will not charge a vaccine administration fee to non-Medicaid federal vaccine eligible children that exceeds the administration fee cap of $20.72 per vaccine dose. For Medicaid children, I will accept the reimbursement for immunization administration set by the state Medicaid agency or the contracted Medicaid health plans.
7.	I will not deny administration of a publicly purchased vaccine to an established patient because the child's parent/guardian/individual of record is unable to pay the administration fee.
8.	I will distribute the current Vaccine Information Statements (VIS) each time a vaccine is administered and maintain records in accordance with the National Childhood Vaccine Injury Act (NCVIA), which includes reporting clinically significant adverse events to the Vaccine Adverse Event Reporting System (VAERS). I will provide an Immunization Information Statement prior to administration of nirsevimab. If a COVID-19 VIS is not available, I will provide an Emergency Use Administration Fact Sheet for Recipients, Emergency Use Instructions, or BLA package insert, as applicable, prior to administration.
9.	I will comply with the requirements for vaccine management including: a) Ordering vaccine and maintaining appropriate vaccine inventories; b) Not store vaccine in dormitory-style units at any time; c) Store vaccine under proper storage conditions at all times. Refrigerator and freezer vaccine storage units and temperature monitoring equipment and practices must meet Utah Department of Health and Human Services storage and handling recommendations and requirements; d) Return all spoiled/expired public vaccines to CDC's centralized vaccine distributor within six months of spoilage/expiration

10.	I agree to operate within the VFC program in a manner intended to avoid fraud and abuse. Consistent with "fraud" and "abuse" as defined in the Medicaid regulations at 42 CFR § 455.2, and for the purposes of the VFC Program: **Fraud:** is an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law. **Abuse:** provider practices that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to the Medicaid program, (and/or including actions that result in an unnecessary cost to the immunization program, a health insurance company, or a patient); or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program.
11.	I will participate in VFC program compliance site visits including unannounced visits, and other educational opportunities associated with VFC program requirements.
12.	I understand this facility or the Utah Department of Health and Human Services may terminate this agreement at any time. If I choose to terminate this agreement, I will properly return any unused federal vaccine as directed by the Utah Department of Health and Human Services.
13.	For pharmacies, urgent care, or school located vaccine clinics, I agree to: a) Vaccinate all "walk-in" VFC-eligible children and b) Will not refuse to vaccinate VFC-eligible children based on a parent's inability to pay the administration fee. Note: *"Walk-in" refers to any VFC eligible child who presents requesting a vaccine; not just established patients. "Walk-in" does not mean that a provider must serve VFC patients without an appointment. If a provider's office policy is for all patients to make an appointment to receive immunizations then the policy would apply to VFC patients as well.*
14.	I agree to replace vaccine purchased with federal funds (VFC, 317) that are deemed non-viable due to provider negligence on a dose-for-dose basis.
15.	I will submit to the Utah Statewide Immunization Information System (USIIS) detailed information regarding all administered doses of vaccines, regardless of the patient age or eligibility status. Vaccine record submission will include specifics about the vaccine and eligibility category by dose and should occur within 14 days of vaccine administration. I will also utilize the vaccine ordering, inventory, and doses administered modules as part of vaccine accountability.

By signing this form, I certify on behalf of myself and all immunization providers in this facility, I have read and agree to the Vaccines for Children enrollment requirements listed above and understand I am accountable (and each listed provider is individually accountable) for compliance with these requirements.	
Medical Director or Equivalent Name (print):	
Signature:	Date:

ADDITIONAL PROVIDERS

PROVIDERS PRACTICING AT THIS FACILITY *(attach additional pages as necessary)*				
Instructions: *List below all licensed health care providers (MD, DO, NP, PA, pharmacist) at your facility who have prescribing authority and will authorize vaccine administration.*				
Provider Name	**Title**	**License No.**	**Medicaid or NPI No.**	**EIN**

Vaccines for Children (VFC) Program
Provider Profile Form

All health care providers participating in the Vaccines for Children (VFC) program must complete this form annually or more frequently if the number of children served changes or the status of the facility changes during the calendar year.

Date: ____/____/_____

FACILITY INFORMATION		
Vaccine Delivery Address:		
Vaccine Delivery Days and Times:		
Special Instructions (i.e. lunch hour, etc.) *Note: Notify the Utah VFC Program if this schedule changes (vacation, closure, etc.)*		
City:	State:	Zip:
Telephone:	Email:	Fax:

FACILITY TYPE (select facility type)		
Private Facilities	**Public Facilities**	
❑ Private Hospital ❑ Private Practice (solo/group/HMO) ❑ Private Practice (solo/groups as agent for FQHC/RHC-deputized) ❑ Community Health Center ❑ Pharmacy ❑ Birthing Hospital ❑ School-Based Clinic ❑ Teen Health Center ❑ Adolescent Only Providers ❑ Other_____	❑ Public Health Department Clinic ❑ Public Health Department Clinic as agent for FQHC/RHC deputized ❑ Public Hospital ❑ FQHC/RHC (Community/Migrant/Rural) ❑ Community Health Center ❑ Tribal/Indian Health Services Clinic ❑ Women Infants and Children ❑ Other_____	❑ STD/HIV ❑ Family Planning ❑ Juvenile Detention Center ❑ Correctional Facility ❑ Drug Treatment Facility ❑ Migrant Health Facility ❑ Refugee Health Facility ❑ School-Based Clinic ❑ Teen Health Center ❑ Adolescent Only

VACCINE OFFERED (select only one box)

❑ All ACIP Recommended Vaccines for children 0 through 18 years of age.

❑ Offers Select Vaccines **(This option is only available for facilities designated as Specialty Providers by the VFC Program).**

A "Specialty Provider" is defined as a provider that only serves (1) a defined population due to the practice specialty (e.g. OB/GYN; STD clinic, family planning) or (2) a specific age group within the general population of children ages 0-18. Local health departments and pediatricians are not considered specialty providers. The VFC Program has the authority to designate VFC providers as specialty providers. At the discretion of the VFC Program, enrolled providers such as pharmacies and mass vaccinators may offer only influenza vaccine.

Select Vaccines Offered by Specialty Provider:		
❑ COVID-19 ❑ DTaP ❑ Hepatitis A ❑ Hepatitis B ❑ HIB ❑ HPV	❑ Influenza ❑ Meningococcal Conjugate ACWY ❑ Meningococcal Conjugate B ❑ MMR ❑ Pneumococcal Conjugate ❑ Pneumococcal Polysaccharide	❑ Polio ❑ Rotavirus ❑ RSV ❑ TD ❑ Tdap ❑ Varicella

PROVIDER POPULATION

Provider population based on patients seen during the previous 12 months. *Report the number of children who received vaccinations at your facility, by age group. Only count a child once based on the status at the last immunization visit, regardless of the number of visits made. The following table documents how many children received VFC vaccine, by category, and how many received non-VFC vaccine.*

VFC Vaccine Eligibility Categories	# of children who received VFC Vaccine by Age Category			
	<1 Year	1-6 Years	7-18 Years	Total
Enrolled in Medicaid				
No Health Insurance				
American Indian/Alaska Native				
Underinsured in FQHC/RHC or deputized facility[1]				
Total VFC:				
Non- VFC Vaccine Eligibility Categories	**# of children who received non-VFC Vaccine by Age Category**			
	<1 Year	**1-6 Years**	**7-18 Years**	**Total**
Insured (private pay/health insurance covers vaccines)				
Children's Health Insurance Program (CHIP)[2]				
Total Non-VFC:				
Total Patients (must equal sum of Total VFC + Total Non-VFC)				

TYPE OF DATA USED TO DETERMINE PROVIDER POPULATION (choose all that apply)

- ❑ Benchmarking
- ❑ Medicaid Claims Data
- ❑ IIS (USIIS)
- ❑ Other (must describe):
- ❑ Doses Administered
- ❑ Provider Encounter Data
- ❑ Billing System

[1] Underinsured includes children with health insurance that does not include vaccines or only covers specific vaccine types. Children are only eligible for vaccines that are not covered by insurance.

In addition, to receive VFC vaccine, underinsured children must be vaccinated through a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) or under an approved deputized provider. The deputized provider must have a written agreement with an FQHC/RHC and the state/territorial immunization program in order to vaccinate these underinsured children.

[2] CHIP – Children enrolled in the state Children's Health Insurance Program (CHIP). These children are considered insured and are not eligible for vaccines through the VFC program. Each state provides specific guidance on how CHIP vaccine is purchased and administered through participating providers.

This record is to be submitted to and kept on file with the Utah Department of Health and Human Services Immunization Program, and must be updated yearly. ***A copy of this completed document is considered the same as the original.***

Send emailed form to:

immunize@utah.gov

UTAH VFC PROGRAM USE ONLY

Date Received:_____

Class Code: ❑ Health Dept. ❑ Private ❑FQHC/RHC ❑ Hospital ❑ Pharmacy ❑ Other Public

Date Approved:_____ Approved By:_____

UCMS Entry Date:_____ UCMS Entry By:_____