



Provider Profile and Enrollment

Clinic Name: _____

Type of Facility: A. Public Health Department D. Certified Rural Health Clinic (RHC)*
 B. Private Practice (Individual or Group) E. Other Facility _____
 C. Federally Qualified Health Center (FQHC)

*Note: If claiming FQHC or RHC status, you must be Federally certified.

Contact Person: _____
First Last Title

Vaccine Delivery Address: _____
Street Only (No P.O. Boxes)

City State Zip

Mailing Address: _____
Street or PO Box

City State Zip

Email Address: _____

Telephone: () _____ Extension _____ Fax: () _____

Vaccine Delivery Days and Times: _____

Special Instructions: (i.e. lunch hour, etc) _____

Note: Please Notify the Utah VFC Program if this schedule changes (vacation, closure, etc.)

PART I: Provider Agreement

To participate in the Utah Vaccines for Children (VFC) Program and receive publicly funded (CFDA 93.268, DHHS/CDC Grant 5H231P822520-05) vaccine at my facility for no cost, I agree to the following conditions, on behalf of myself and all the practitioners, nurses and others associated with this medical office, group practice, health department, or other health delivery facility of which I am the physician-in-chief, health officer, or equivalent:

1. I will screen patients for eligibility at all immunization encounters and administer publicly funded vaccine only to children, 0 through 18 years of age, who qualify under one or more of the following categories: a) Is an American Indian or Alaskan Native; b) Is enrolled in Medicaid; c) Has no health insurance; d) Has health insurance that does not include coverage of vaccines, covers only selected vaccines, or caps vaccine coverage at an annual limit (under-insured); or e) Is enrolled in the Children's Health Insurance Program (CHIP).
2. I will comply with the appropriate immunization schedule, dosage, and contraindications, that are established by the Advisory Committee on Immunization Practices (ACIP) and included in the Utah VFC Program, unless a) in my medical judgment, and in accordance with accepted medical practice, I deem such compliance to be medically inappropriate; or b) the parent/guardian claims an exemption to immunizations in accordance with the *Immunization Rule for Students* (R396-100).

Provider Agreement (continued)

3. I will maintain parent/guardian responses to the Patient Eligibility Screening Record as part of the child's permanent medical record for a period of seven years. I will maintain all other records related to the Utah VFC Program for a minimum of three years and make all records available to the Utah Department of Health (UDOH) and/or the Department of Health and Human Services (DHHS) staff during routine site visits and upon request.
4. I will immunize eligible children at no charge to the patient for the vaccine.
5. I will not impose a charge for the administration of the vaccine that exceeds the maximum fee of \$14.52 per dose as established by the Center for Medicare and Medicaid Services (CMS). I will accept the vaccine administration reimbursement fee set by Utah Medicaid and contracted Medicaid health plans.
6. I will not deny administration of a publicly funded vaccine to a child because the child's parent/guardian of record is unable to pay the administration fee.
7. I will distribute the most current Vaccine Information Statements (VIS) each time a vaccine is administered and maintain records in accordance with the National Childhood Vaccine Injury Compensation Act (NCVICA), which includes reporting clinically significant adverse events to the Vaccine Adverse Event Reporting System (VAERS).
8. I will comply with Utah VFC Program requirements for vaccine ordering, submission of vaccine inventories, and submission of temperature logs as requested.
9. I will comply with Utah VFC Program requirements for submission of the Quarterly Doses Administered Report. I will operate in a manner intended to avoid fraud and abuse.
10. I will appropriately store and handle vaccines according to the Centers for Disease Control and Prevention (CDC), the Utah VFC Program, and vaccine manufacturer guidelines, which include: appropriate refrigeration equipment, temperature monitoring, immediately storing vaccine shipments, and rotating vaccine stock.
11. I will not pre-fill vaccine syringes prior to use and will only fill syringes at the time of administration.
12. I will develop a written policy on the routine storage, handling, and transport of vaccines, and review with staff annually. I will designate primary and back-up vaccine coordinators responsible for vaccine management.
13. I will develop a written policy on the emergency handling of vaccine (a plan of action should a storage problem occur) and post notices to prevent power from being disconnected from refrigeration units.
14. I will maintain appropriate levels of vaccine inventory, avoid vaccine stockpiling, and clearly distinguish between public and private vaccine stocks.
15. I will notify the Utah VFC Program of any vaccine loss and I agree to reimburse for any vaccine loss in excess of \$1,000.00 due to inappropriate vaccine storage and handling, if requested.
16. I will be responsible for returning all non-viable publicly funded vaccines directly to McKesson Specialty Distribution and notify the Utah VFC Program in accordance with policy and instructions.
17. I will notify the Utah VFC Program if my practice closes or no longer serves VFC eligible clients, submit a final Quarterly Doses Administered Report, and agree to properly transport any remaining VFC vaccines to another VFC Provider.
18. The Utah VFC Program may terminate this agreement at any time for failure to comply with these requirements or I may terminate this agreement at any time for personal reasons.

Signature of physician-in-chief, health officer, or equivalent

Print Name

Date

Provider Profile (continued)

PART II: Provider Profile

A. For the 2010 calendar year, project the number of **ALL children** (VFC eligible and non-VFC) who will receive vaccinations at your facility, by age group.

Numbers of ALL children who will receive vaccine in your facility in the coming year:	<1 Year Old	1-6 Years	7-18 Years	Total

B. Of the total number of children entered above (section A), how many are expected to be eligible for publicly funded vaccine, by age group and category?

	<1 Year	1-6 Years	7-18 Years	Total
VFC - Enrolled in Medicaid				
VFC - No health insurance				
VFC - Am. Indian/Alaskan Nat.				
Under-insured				
CHIP				
Total				

Type of data used to determine projections:

- | | |
|---|--|
| <p>A. <input type="checkbox"/> Benchmarking Data</p> <p>B. <input type="checkbox"/> Medicaid Claims Data</p> <p>C. <input type="checkbox"/> Provider Encounter Data</p> | <p>D. <input type="checkbox"/> Registry Data (USIIS)</p> <p>E. <input type="checkbox"/> Doses Administered Data</p> <p>F. <input type="checkbox"/> Other _____
(Specify)</p> |
|---|--|

PART III: Provider Information

Please VERIFY for accuracy the names and medical license numbers of ALL Health Providers, including signing physician, who may prescribe vaccine. Please make corrections or add additional providers as needed. It is not necessary to include the names of staff who may administer vaccine, but rather, only those who possess a medical license or are authorized to write prescriptions.

Last Name, First, MI	Title (MD, DO, ND, NP, PA)	Medicaid Provider No.	Specialty Peds, Family Med, GP, Other (specify)
		Medical License No.	
Last Name, First, MI	Title (MD, DO, ND, NP, PA)	Medicaid Provider No.	Specialty Peds, Family Med, GP, Other (specify)
		Medical License No.	
Last Name, First, MI	Title (MD, DO, ND, NP, PA)	Medicaid Provider No.	Specialty Peds, Family Med, GP, Other (specify)
		Medical License No.	
Last Name, First, MI	Title (MD, DO, ND, NP, PA)	Medicaid Provider No.	Specialty Peds, Family Med, GP, Other (specify)
		Medical License No.	

Medical License No.

Provider Information (continued)

_____	_____	_____	_____
Last Name, First, MI	Title (MD, DO, ND, NP, PA)	Medicaid Provider No.	Specialty Peds, Family Med, GP, Other (specify)

		Medical License No.	
_____	_____	_____	_____
Last Name, First, MI	Title (MD, DO, ND, NP, PA)	Medicaid Provider No.	Specialty Peds, Family Med, GP, Other (specify)

		Medical License No.	
_____	_____	_____	_____
Last Name, First, MI	Title (MD, DO, ND, NP, PA)	Medicaid Provider No.	Specialty Peds, Family Med, GP, Other (specify)

		Medical License No.	
_____	_____	_____	_____
Last Name, First, MI	Title (MD, DO, ND, NP, PA)	Medicaid Provider No.	Specialty Peds, Family Med, GP, Other (specify)

		Medical License No.	
_____	_____	_____	_____
Last Name, First, MI	Title (MD, DO, ND, NP, PA)	Medicaid Provider No.	Specialty Peds, Family Med, GP, Other (specify)

		Medical License No.	

This record is to be submitted to and kept on file with the Utah Department of Health Immunization Program, and must be updated yearly. The original form must be mailed, no faxed copies will be accepted.

Please Mail Form to:
Utah Department of Health
Immunization Program
PO Box 142001
Salt Lake City, UT 84114-2001
Phone: (801) 538-9450

UTAH VFC PROGRAM USE ONLY

Date Received: _____

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

Approved By: _____
(Signature)

Date Approved: _____

VACMAN Entry Date: _____

VACMAN Entry By: _____
(Signature)