

2016/2017 VACCINES FOR ADULTS PROGRAM PROVIDER AGREEMENT

FACILITY INFORMATION			
Facility Name:			VFA Pin#:
Facility Address:			
City:	County:	State:	Zip:
Telephone:		Fax:	
Shipping Address (if different than facility address):			
City:	County:	State:	Zip:
MEDICAL DIRECTOR OR EQUIVALENT			
Instructions: <i>The official VFA 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 VFA providers with the responsible conditions outlined in the provider enrollment agreement. The individual listed here must sign the provider agreement.</i>			
Last Name, First, MI:		Title:	Specialty:
License No.:		Medicaid or NPI No.:	Employer Identification No. (optional):
<i>Provide Information for second individual as needed:</i>			
Last Name, First, MI:		Title:	Specialty:
License No.:		Medicaid or NPI No.:	Employer Identification No. (optional):
VFA VACCINE COORDINATOR			
Primary Vaccine Coordinator Name:			
Telephone:		Email:	
Completed annual training: <input type="radio"/> Yes <input type="radio"/> No		Type of training received:	
Back-Up Vaccine Coordinator Name:			
Telephone:		Email:	
Completed annual training: <input type="radio"/> Yes <input type="radio"/> No		Type of training received:	

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 equivalent:

1.	I will annually submit a VFA enrollment form or more frequently if there is a change in Medical Director or the population served.
2.	I will screen patients and document patients age at each immunization encounter for VFA eligibility and administer VFA-purchased vaccine only to adults age 19-64. Adults aged 65 and older are not eligible to receive VFA-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 VFA program unless: <ol style="list-style-type: none"> 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 adult; b) The particular requirements contradict state law, including laws pertaining to religious and other exemptions.
4.	I will maintain all records related to the VFA program for a minimum of three years and upon request make these records available for review. VFA records include, but are not limited to, VFA screening documentation, billing records, medical records that verify receipt of vaccine, vaccine ordering records, and vaccine purchase and accountability records.
5.	I will immunize eligible adults with publicly supplied vaccine at no charge to the patient for the vaccine.
6.	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.
7.	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).
8.	I will comply with the requirements for vaccine management including: <ol style="list-style-type: none"> a) Ordering vaccine and maintaining appropriate vaccine inventories; b) Not storing vaccine in dormitory-style units at any time; c) Storing vaccine under proper storage conditions at all times. Refrigerator and freezer vaccine storage units and temperature monitoring equipment and practices must meet Vermont Immunization Program storage and handling recommendations and requirements; d) Returning all spoiled/expired public vaccines to CDC's centralized vaccine distributor within six months of spoilage/expiration
9.	I will participate in VFA program compliance site visits including unannounced visits, and other educational opportunities associated with VFA program requirements.

10.	Vermont health care providers must report to Vermont Department of Health immunization data for adults 18 years and older, within one month after the health care provider has established an electronic health records system and data interface pursuant to the e-health standards developed by the Vermont information technology leaders. (Vermont Statutes Annotated, 18, Chapter 21 § 1129. Immunization Registry).
11.	I understand this facility or the Vermont Immunization Program 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 Vermont Immunization Program.

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 Adults 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:

Name (print) *Second individual as needed:*

Signature:

Date:

Vaccines for ADULTS (VFA) Program Provider Profile Form

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

Date: ____/____/____

Provider Identification Number# _____

FACILITY INFORMATION

Provider's Name:		
Facility Name:		
Vaccine Delivery Address:		
City:	State:	Zip:
Telephone:	Email:	

FACILITY TYPE (select facility type)

Private Facilities	Public Facilities		
<input type="checkbox"/> Private Hospital <input type="checkbox"/> Private Practice (solo/group/HMO) <input type="checkbox"/> Private Practice (solo/groups as agent for FQHC/RHC-deputized) <input type="checkbox"/> Community Health Center <input type="checkbox"/> Pharmacy <input type="checkbox"/> Birthing Hospital <input type="checkbox"/> Other _____	<table style="width: 100%;"> <tr> <td style="width: 60%;"> <input type="checkbox"/> Public Health Department Clinic <input type="checkbox"/> Public Health Department Clinic as agent for FQHC/RHC-deputized <input type="checkbox"/> Public Hospital <input type="checkbox"/> FQHC/RHC (Community/Migrant/Rural) <input type="checkbox"/> Community Health Center <input type="checkbox"/> Tribal/Indian Health Services Clinic <input type="checkbox"/> Other _____ </td> <td style="width: 40%;"> <input type="checkbox"/> STD/HIV <input type="checkbox"/> Family Planning <input type="checkbox"/> Correctional Facility <input type="checkbox"/> Drug Treatment Facility <input type="checkbox"/> Migrant Health Facility <input type="checkbox"/> Refugee Health Facility </td> </tr> </table>	<input type="checkbox"/> Public Health Department Clinic <input type="checkbox"/> Public Health Department Clinic as agent for FQHC/RHC-deputized <input type="checkbox"/> Public Hospital <input type="checkbox"/> FQHC/RHC (Community/Migrant/Rural) <input type="checkbox"/> Community Health Center <input type="checkbox"/> Tribal/Indian Health Services Clinic <input type="checkbox"/> Other _____	<input type="checkbox"/> STD/HIV <input type="checkbox"/> Family Planning <input type="checkbox"/> Correctional Facility <input type="checkbox"/> Drug Treatment Facility <input type="checkbox"/> Migrant Health Facility <input type="checkbox"/> Refugee Health Facility
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VACCINES OFFERED (select all that apply)

Select Vaccines you would like to offer:

<input type="radio"/> MMR	<input type="radio"/> Meningococcal Conjugate
<input type="radio"/> Hepatitis A	<input type="radio"/> TD
<input type="radio"/> Hepatitis B	<input type="radio"/> Pneumococcal Conjugate
<input type="radio"/> HZV (Shingles)	<input type="radio"/> Pneumococcal Polysaccharide
<input type="radio"/> HPV	<input type="radio"/> Varicella
<input type="radio"/> Tdap	<input type="radio"/> MENB

PROVIDER POPULATION

The following information is used to determine the amount of vaccine needed for your practice and **must be based on actual data**, not estimates. Provider Population is based on patients seen during the previous 12 months. Report the number of adults who received vaccinations at your facility. Only count an adult once based on the status at the last immunization visit, regardless of the number of visits made.

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

<input type="radio"/> Benchmarking	<input type="radio"/> Doses Administered
<input type="radio"/> Medicaid Claims	<input type="radio"/> Provider Encounter Data
<input type="radio"/> IIS	<input type="radio"/> Billing System
<input type="radio"/> Other (must describe):	

Number of adult patients	Total Number of Adults 19-64 years

2016-2017 Provider Agreement and Guidelines for Varicella and Herpes Zoster Vaccines

STORAGE REQUIREMENTS: If you wish to receive varicella or herpes zoster vaccine you will have to complete this signed agreement showing that your practice meets the following guidelines for proper storage and handling.

- a) Merck & Company, Inc. the manufacturer of Varivax and Zostavax will pack and ship vaccine directly to the provider office after receiving an order from CDC which is submitted through Vermont Immunization Registry (IMR).
- b) Vaccines **MUST** be stored in a freezer, and **MUST** maintain temperatures between -15°C to -50°C (+5°F to -58°F).
- c) The freezer **MUST** have a separate door from the refrigerator, (e.g. stand alone freezer). Dorm-style or larger refrigerator/freezer combinations where the freezer is within the refrigerator is **NOT** acceptable.
- d) A continuous monitoring device (data logger) with current certificate of traceability and calibration must be placed in the freezer.
- e) Freezer temperatures must be recorded twice a day as well as time and initials for each reading and any out of range temperatures **MUST** be reported to the Immunization Program immediately. Please call 1-802-863-7638.
- f) State and/or VFA supplied varicella or herpes zoster vaccine **cannot be moved or redistributed from the provider site that received it without permission from the Vermont Immunization Program.**

Practice PIN: _____

Practice Name: _____

Vaccine Contact Name: _____

Contact Telephone Number: _____

I agree to the additional conditions herein for the storage, handling and use of varicella and zoster vaccine.

Signature of Medical Director or Equivalent

Date