

2012 Vaccines for Children Provider Enrollment Form

Each line or field must be filled out completely.

Practice/Facility Name _____ VFC PIN # _____

Contact Name _____ County _____

Shipping Address _____
Street (No PO Box) City State Zip Code

Mailing Address _____
Street (No PO Box) City State Zip Code

Telephone # (_____) _____ Fax # (_____) _____

Facility Medicaid Provider # (if applicable) _____ Federal Tax ID # _____

E-mail Address _____

Hours of Operation/Delivery Instructions _____

Is your practice/facility:

Licensed Federally Qualified Health Center (FQHC) Yes **or** No

Licensed Rural Health Clinic (RHC) Yes **or** No

Neither

All state approved public and private health care providers participating in the Vaccines for Children/State Children's Health Insurance Program (VFC/SCHIP) must complete this form. This document provides shipping information and helps the State determine the amount of vaccine to be supplied through VFC/SCHIP. This form also may be used to compare estimated vaccine needs with actual vaccine supply. VFC eligibility status must be updated annually or more frequently if (1) the number of children being served changes and/or (2) the status of the facility changes (e.g., the provider becomes an agent of a Federally Qualified Health Center or Rural Health Clinic).

Type of Facility:

- | | |
|---|--|
| <input type="checkbox"/> A. Public Health Department | <input type="checkbox"/> D. Private Practice (individual or group) |
| <input type="checkbox"/> B. Public Hospital | <input type="checkbox"/> E. Private Hospital |
| <input type="checkbox"/> C. Other Public Facility*^ _____ | <input type="checkbox"/> F. Other Private Facility*^^ _____ |

If clinic is part of joint ownership/operating arrangement (name) _____

*^Other Public Facilities include: Military health care facilities; Indian Health Centers; public hospital-based clinics including university/resident clinics; public preschool/day care/head start; WIC sites; Corrections facilities, HIV/STD clinics, substance abuse clinics.

*^^Other Private Facilities include: privately-owned, hospital-based clinics, including university/resident clinics; HMO; private preschool/day care/head start clinic.

2012 Contract Requirements

PIN #

As a condition of participation in the Vaccines for Children/State Children’s Health Insurance Program (VFC/SCHIP) and receive federally-procured vaccine, the above-referenced Practice/Facility agrees to the following terms, on behalf of all the practitioners, nurses and others associated with this Practice/Facility.

1. VFC/SCHIP program-purchased vaccine shall be provided only to a child, through 18 years of age, who qualifies under one or more of the following categories: (1) Is an American Indian or Alaskan Native; (2) Is on Medicaid (or qualifies through a State Medicaid waiver); (3) Has no health insurance; (4) Has health insurance that does not pay for the vaccine (only applicable for licensed FQHC’s, licensed RHC’s or HD’s); or (5) through SCHIP (HW21) funding. VFC eligibility shall be confirmed at each immunization visit.
2. A Monthly Immunization Report (MIR) accompanied by corresponding temperature logs and the wasted vaccine form shall be submitted monthly to the Kansas Immunization Program on a monthly basis, by the 10th day of the month following the reporting month.
3. All vaccines shall be administered as recommended by the Advisory Committee on Immunization Practices (ACIP) provided through the VFC/SCHIP Program.
4. Eligibility screening records and other records related to the VFC program shall be maintained for a period of 3 years. Release of such records will be bound by the privacy protection of the federal law.
5. All records related to the VFC program shall be made available to the Kansas Immunization Program or to the United States Department of Health and Human Services upon request, during site visits and staff in-services, including assessment of immunization rates.
6. Administration of vaccines shall comply with the appropriate immunization schedule, dosage, and contraindications that are established by the ACIP, unless in provider’s medical judgment, and in accordance with accepted medical practice, provider deems such compliance to be medically inappropriate.
7. The most current Vaccine Information Statements (VIS’s) shall be distributed 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. There shall be no charge for the cost of VFC procured vaccine. Provider will not charge a vaccine administration fee to the non-Medicaid VFC-eligible child that exceeds the fee cap of \$14.80 per dose. For Medicaid VFC-eligible children, Provider agrees to accept the reimbursement for immunization administration set by the state Medicaid agency or the contracted Medicaid health plans.
9. VFC procured vaccine shall not be denied to an eligible child because the child’s parent/guardian or the individual of record is unable to pay the administration fee.
10. Kansas requirements for ordering, vaccine accountability, and vaccine management shall be maintained, and the Practice/Facility shall operate within the VFC program in a manner intended to avoid negligence, fraud and abuse. Kansas Immunization Program Vaccine Management policies and procedures describe provider accountability for avoidable wasted vaccine and unaccounted for vaccine.
11. Proper storage and handling standards for vaccines as outlined in the CDC’s Vaccine Storage & Handling Toolkit shall be maintained.
12. An annual enrollment form shall be submitted at the beginning of each calendar year. During the year, Provider will notify the Kansas Immunization Program immediately of any changes in pertinent information relative to the enrollment form.
13. The Kansas Immunization Program may terminate this agreement at any time for failure to comply with these requirements. Provider may terminate this agreement at any time by notifying the Kansas Immunization Program, completing the formal disenrollment process, and returning any remaining VFC vaccine. Re-enrollment will be at the discretion of the KIP Director.
14. The Practice/Facility shall be bound by CDC’s terms of use for interacting with the online ordering system, and shall be bound by any applicable federal laws, regulations or guidelines related to accessing a CDC system and ordering publically funded vaccines.
15. In advance of any VTrackS access each member of the Practice/Facility staff or representative who is authorized to order vaccines shall be identified. In addition, the Practice/Facility shall maintain a record of each staff member who is authorized to order vaccines. If changes occur, CDC and Kansas Immunization Program shall be notified within 24 hours of any change in status of current staff members or representatives who are no longer authorized to order vaccines, or the addition of any new staff authorized to order.

Medical Director (requires signature of MD, DO, ND, NP or PA)

Date

Printed Name of Medical Director

**2012 Health Care Providers
(Please Print Names)**

PIN #

The National Provider Identifier (NPI) and License Number is required for all listed providers on this page. The license number is necessary for any provider at the site who is authorized under state law to prescribe vaccines. This enrollment will not be processed without all requested data.

First Name MI Last Name, Title: MD, DO, ND, NP or PA	NPI	License Number	Specialty: Family Med, Peds, GP, etc.
First Name MI Last Name, Title: MD, DO, ND, NP or PA	NPI	License Number	Specialty: Family Med, Peds, GP, etc.
First Name MI Last Name, Title: MD, DO, ND, NP or PA	NPI	License Number	Specialty: Family Med, Peds, GP, etc.
First Name MI Last Name, Title: MD, DO, ND, NP or PA	NPI	License Number	Specialty: Family Med, Peds, GP, etc.
First Name MI Last Name, Title: MD, DO, ND, NP or PA	NPI	License Number)	Specialty: Family Med, Peds, GP, etc.
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First Name MI Last Name, Title: MD, DO, ND, NP or PA	NPI	License Number)	Specialty: Family Med, Peds, GP, etc.
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First Name MI Last Name, Title: MD, DO, ND, NP or PA	NPI	License Number	Specialty: Family Med, Peds, GP, etc.

Photocopy this page for additional providers.

2012 Eligibility/Profile Status

PIN #

Document the data requested in the boxes below. Doses administered data must be converted into the numbers of children being served. The accuracy of this data is vital to determine vaccine usage and economic order quantity (EOQ). Data must be updated when numbers of children in practice change. Formulas may be developed which convert doses of specific antigens administered into population estimates by ages and eligibility categories. (Attach formula to enrollment form.)

Part A. For the upcoming twelve-month period, project the total number of all **children** who will be vaccinated at your facility, by age. This includes non-VFC **AND** VFC children; these numbers will be the **same as or more than** the totals in Part B.

Total Number of ALL Children in Practice Regardless of Eligibility	<1 Year Old	1-2 Years	3-6 Years	7-18 Years	Total

Part B. Project the number of **children** included, in Part A, who is expected to be **VFC/SCHIP eligible** by age and eligibility category. Information derived from the Monthly Immunization Report or KsWebIZ VFC Vaccine Category Report will help in compiling this information.

Eligibility Categories	Only VFC Children in Practice				
	<1 Year	1-2 Years	3-6 Years	7-18 Years	Total
Medicaid (HW19)					
Uninsured					
American Indian/ Alaskan Native					
Underinsured (FQHC or RHC or LHD only)					
State Insured (HW21)					
Total VFC Eligible					

Type of data used to determine eligibility status:

- | | |
|--|---|
| <input type="checkbox"/> A. Benchmarking Data | <input type="checkbox"/> B. Medicaid Claims Data |
| <input type="checkbox"/> C. Provider Encounter Data | <input type="checkbox"/> D. Registry Data |
| <input type="checkbox"/> E. Vaccine Replacement Data | <input type="checkbox"/> F. Doses Administered Data |
| <input type="checkbox"/> G. Prior Ordering Data | <input type="checkbox"/> H. Other _____ |

Retain a copy of this form for your files and remit a copy to:
 Kansas Immunization Program, 1000 SW Jackson Street, Suite 075, Topeka KS 66612-1274
 Phone 785/296-5591; Fax 785/296-6510