STATE OF ALABAMA DEPARTMENT OF
PUBLIC HEALTH

Thomas M. Miller, M.D.
Acting State Health Officer

Dear Health Care Provider:

SUBJECT: Alabama Vaccines for Children (VFC) Program Enrollment Packet

Thank you for your interest in the Alabama VFC Program.

To enroll in the VFC program, please complete all forms, scan, and email them to immunization@adph.state.al.us or fax to 1-800-706-8507:

1. Provider Agreement
2. Provider Profile Form
3. Medicaid Data Sheet
4. Capacity to Store All Vaccines (e.g., VARIVAX & ProQuad)
5. Emergency Response Plan
6. VTrckS ID Voucher

After your enrollment forms are processed, a VFC Program representative will contact your office to arrange an initial visit to:

- Review the VFC Program
- Provide you and your staff with immunization-related materials
- Provide continuing education if desired
- Review your vaccine storage and handling procedures
- Answer any questions that you may have
- Train you and your staff on the Centers for Disease Control and Prevention (CDC) online vaccine ordering system (VTrckS), and
- Place your first vaccine order at that time

Periodic quality assurance site visits by a VFC Program representative are required. The legislation that created the VFC Program states that the provider must:

- make records of patients served by the VFC Program available to the state
- participate in VFC program compliance site visits including unannounced visits and other educational opportunities associated with VFC program requirements.

Follow-up visits generate educational experiences for you and your staff, help you correct areas to improve your immunization practices, and help you build a well-organized VFC clinic.

Please contact the Alabama VFC Program at 1-866-674-4807 for any questions that you may have.

The entire staff of the Alabama VFC Program thanks you and looks forward to a long-lasting business relationship.

Sincerely yours,

Denise Strickland
Director, Vaccines for Children Program

Enclosures
CL/ds

ALABAMA Vaccines for Children PROGRAM

VACCINES FOR CHILDREN PROGRAM PROVIDER AGREEMENT

FACILITY INFORMATION			
Facility Name:			VFC Pin (new providers leave blank):
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 No. *(optional):*

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.*

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 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 three years, or longer if 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 $19.79 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).
9.	I will comply with the requirements for vaccine management including: 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 Immunization Program storage and handling requirements; d) Returning 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.
CDC VFC REQUIREMENTS TO SUPPORT AWARDEE IMMUNIZATION PROGRAM POLICY	
	Should my staff, representative, or I access VTrckS, I agree to: a) Be bound by CDC's terms of use for interacting with the online ordering system. I further agree to be bound by any applicable federal laws, regulations or guidelines related to accessing a CDC system and ordering publically funded vaccines, and b) In advance of any VTrckS access by my staff, representative or myself, I will identify each member of my staff or representative who is authorized to order vaccines on my behalf. In addition, I will maintain a record of each staff member who is authorized to order vaccines on my behalf. If changes occur, I will inform my state, local, or territorial immunization program 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 on my behalf. I certify that my identification is represented correctly on this provider enrollment form.
	For providers with a signed deputization Memorandum of Understanding between a FQHC or RHC and the state/local immunization program to serve underinsured VFC-eligible children, I agree to: a) Include "underinsured" as a VFC eligibility category during the screening for VFC eligibility at every visit; b) Vaccinate "walk-in" VFC-eligible underinsured children; and c) Report required usage data Note: *"Walk-in" in this context refers to any underinsured child who presents requesting a vaccine; not just established patients.*

	"Walk-in" does not mean that a provider must serve underinsured 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 underinsured patients as well.
	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.*
12.	I understand this facility or the 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 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 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:

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: ___ ___ /___ ___/ ___ ___ ___ ___ VFC PIN# (if new provider, leave blank): _____

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

FACILITY TYPE (select facility type)

Private Facilities	Public Facilities	
☐ Private Hospital	☐ Public Health Department Clinic	☐ STD/HIV
☐ Private Practice (solo/group/HMO)	☐ Public Health Department Clinic as agent for FQHC/RHC-deputized	☐ Family Planning
☐ Private Practice (solo/groups as agent for FQHC/RHC-deputized)	☐ Public Hospital	☐ Juvenile Detention Center
☐ Community Health Center	☐ FQHC/RHC (Community/Migrant/Rural)	☐ Correctional Facility
☐ Pharmacy	☐ Community Health Center	☐ Drug Treatment Facility
☐ Birthing Hospital	☐ Tribal/Indian Health Services Clinic	☐ Migrant Health Facility
☐ School-Based Clinic	☐ Woman Infants and children	☐ Refugee Health Facility
☐ Teen Health Center	☐ Other_____	☐ School-Based Clinic
☐ Adolescent Only Provider		☐ Teen Health Center
☐ Other_____		☐ Adolescent Only

VACCINES OFFERED (select only one box)

☐ All ACIP Recommended Vaccines

☐ 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:

○ DTaP	○ Meningococcal Conjugate	○ TD
○ Hepatitis A	○ MMR	○ Tdap
○ Hepatitis B	○ Pneumococcal Conjugate	○ Varicella
○ HIB	○ Pneumococcal Polysaccharide	○ Other, specify:
○ HPV	○ Polio	
○ Influenza	○ Rotavirus	

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)				

[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/local/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.

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

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

2a

Provider Profile Tool

Date Started:______________________ Date Ended:______________________

Indicate with a check for each child vaccinated each day for a 4 week time period, aged 0 through 18 years, as American Indian or Alaskan Native, Insurance Category, and the appropriate age group. At the end of the 4 week period, total the number of checks for each child vaccinated in each age category, multiply x 12 and enter these totals into Part A of the Provider Profile. Total the number of checks for each Insurance category, multiply by 12 and enter these totals into Part B of the Provider Profile. Please make copies as needed.

Patient ID (optional)	**American Indian or Alaskan Native**	**Insurance category: I=Insured; M=Medicaid; N=No Insurance; U=Underinsured**	**Patient Age in Years < 1**	**Patient Age in Years 1-6**	**Patient Age in Years 7-18**
TOTAL					
X 12					

Add all sheets used together to complete the Provider Profile Form.

ALABAMA Vaccines for Children PROGRAM

Medicaid Data Sheet

All providers approved by the Immunization Division for participation in the Vaccines for Children Program (VFC) must complete this form. This document provides information that helps the Immunization Division determine the amount of vaccine to be supplied through the VFC Program. This form will also be used to compare estimated vaccine needs with actual vaccine supply. The Immunization Division must keep this record on file with the Provider Enrollment form and Provider Emergency Plan. The Provider Profile form must be **updated annually.** A tool to assist you with completing this form is included. One form may be completed by one provider for the entire practice or clinic. If one provider is completing the profile for a multiple-provider clinic, please list the names below.

It is not required to be a Medicaid physician/provider to participate in the VFC program, but it is required if you want reimbursement from the Alabama Medicaid Agency for administration of a vaccine. **Please list all physicians, CRNPs and PAs, with their ten-digit National Provider Identifier (NPI) number and effective date for this clinic site** who will be participating under the Provider Enrollment and Provider Profile. In addition, **please list the office or clinics NPI number with effective date** as well. Hospitals with internship or residency programs should also include a list of these physicians and their Medicaid numbers (if they have one).

Thank you for participating in the Alabama VFC Program. _____

VFC/Medicaid Clinic Name: _____

Clinic/Office NPI Number: _____ **Effective Date:** _____

Group/Payee NPI Number (if applicable): _____ **Effective Date:** _____

Clinic Hours of Operation (ex: M-F 8 a.m. – 5 p.m.): _____

Office Hours Closed for Lunch (ex: 12:30-1:30): _____

Physician/CRNP/Title	Ten-digit NPI No.	Medicaid Number	Effective Medicaid Date

ALABAMA Vaccines for Children PROGRAM

Capacity to Store All Vaccines Including Varicella Vaccine (VARIVAX & ProQuad)

PLEASE PRINT

DATE _____

NAME OF PHYSICIAN OFFICE, PRACTICE, CLINIC, HOSPITAL _____

SHIPPING ADDRESS *(Number and Street—No P.O. Boxes)* _____

TELEPHONE (_____)_____

I, on behalf of myself and any and all practitioners and staff associated with this medical office, group practice, health department, community/migrant/rural clinic, or other entity of which I am the physician-in-chief, medical director or equivalent, agree to comply with the following vaccine storage requirements:

Circle all that apply below

1) I have the following type of refrigeration unit acceptable for storing vaccines.
   a. Stand alone refrigerator is a best practice.
   b. Stand alone freezer (e.g., chest freezer, frost-free freezer, manual defrost freezer)
   c. Household refrigerator with separate compartments for refrigerator and freezer with separate exterior doors **(refrigerator portion is the only section that may be used)**
   d. Commercial refrigerator with separate compartments for refrigerator and freezer with separate exterior doors **(refrigerator portion is the only section that may be used)**
2) My refrigerator/freezer will be dedicated to the storage of vaccines. (Food and beverages must not be stored in a vaccine storage unit because this practice results in frequent opening of the door and destabilization of the temperature.)

I understand that non-acceptable freezers include:

- Dormitory-style freezers, and
- Freezers that do not meet temperature criteria.
- Household freezer-refrigerator combination units, (refrigerator portion is the only section that may be used)

I, or my designated staff, will.

3) Protect VARIVAX and ProQuad from exposure to light
4) Store VARIVAX and ProQuad in a freezer that maintains an average temperature of 5°F (-15°C) or colder
5) Use a thermometer to check the temperature in the freezer in which I have stored VARIVAX and ProQuad at least twice each day
6) Not transport VARIVAX and ProQuad from the clinic location to which the vaccine is shipped because the vaccine is so fragile, will reconstitute VARIVAX and ProQuad only with the diluents supplied with the vaccines, and store the diluents at refrigerator or room temperatures.
7) Administer VARIVAX within 30 minutes after reconstitution and discard VARIVAX vaccine not used within 30 minutes after reconstitution, administer ProQuad immediately after reconstitution and discard reconstituted PROQUAD vaccine if not used within 30 minutes.
8) Not freeze reconstituted VARIVAX and ProQuad vaccines.
9) Monitor and document temperatures twice a day on a temperature log specifically for each unit.

Provider Signature_____

Scan & email to: immunization@adph.state.al.us

Or fax to: 1-800-706-8507

ALABAMA Vaccines for Children PROGRAM

Alabama Vaccines for Children
Emergency Response Plan

Submit with enrollment packet and post a copy on outside of refrigerator for all staff

Name of Clinic:	VFC PIN #
Primary Person Responsible:	24 hour Phone:
Secondary Person Responsible:	24 hour Phone:
Person with 24-hour access:	24 hour Phone:

For a Power Outage: If you do not have a generator, identify at least one location with a generator (hospital, 24-hour store, etc.) and contact them to make arrangements ahead of time. Before transporting, call the back-up location site to ensure that their generator is working.

#1. Location & Contact's Name _____ Ph# _____
#2. Location & Contact's Name _____ Ph# _____
How will you be notified of an outage? _____

If your emergency back-up location is more than 30 minutes away and you have a large quantity of vaccine, consider renting a refrigerated truck to transport our vaccine.
Refrigeration Company _____ Ph# _____

Prevent Loss from Expired Vaccines!!

Check and rotate your stock to assure shortest dated vaccine is used first. Notify the VFC Program at 1-866-674-4807 if vaccines are going to expire within 3-6 months.

Check and record refrigerator and freezer temperatures 2 times a day:
1. Once in the morning when the practice opens (includes recording Min/Max temperatures)
2. Once in the afternoon to allow for adjustments prior to the time the practice closes.

What to do if a power failure occurs, refrigerator door was left open, temperature was too cold, refrigerator plug was pulled, or any other situation which would cause improper storage conditions:

1. Close the door and/or plug in the refrigerator/freezer.
2. Record the current temperature of the refrigerator/freezer.
3. Store the vaccines at appropriate temperatures. Make sure that the refrigerator/freezer is working properly or move the vaccines. Do not automatically throw out the affected vaccine. Mark the vaccine so that the potentially compromised vaccines can be easily identified.
4. Collect essential data on the reverse side of this sheet and notify the VFC Program immediately at 1-866-674-4807.

Turn over for Emergency Response Worksheet

ALABAMA Vaccines for Children PROGRAM

Emergency Response Worksheet

1. Current temperature of refrigerator: _____ Max/min temperature reached: _____
2. Current temperature of freezer: _____ Max/min temperature reached: _____
3. Amount of time temperature was outside normal range: refrigerator _____ freezer: _____

REFRIGERATOR

Vaccine	Lot number	Doses

FREEZER

Vaccine	Lot number	Doses

VTrckS Identity Voucher

I, _____ ("user"), have received this voucher from the responsible clinician at my place of business on behalf of the Centers for Disease Control and Prevention ("CDC") in support of the identity verification process for the Vaccine Tracking System (VTrckS). I have received and completed this voucher in an effort to comply with federal identity proofing guidelines as a requirement for becoming a user of CDC's Vaccine Tracking System.

I certify that the attached government photo identification was issued to me and obtained by official means and has not in any way be altered to falsify the photo or of the other identifying information.

ID Type _____ Government ID #: _____

Applicant Address 1: _____

Applicant Address 2: _____

Applicant signature: _____

Applicant e-mail address: _____

Date: _____

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Responsible clinician (PIN _____):

I certify that the applicant listed above is who they claim to be and their government issued identification matches their physical identity.

Responsible clinician name (printed): _____

Responsible clinician signature: _____

Date: _____

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This document must be kept on file with the provider for seven years and six months from the date of user deactivation in VTrckS , regardless of the user's employment status (i.e., currently employed or no longer employed by the clinic).

Deactivation date in VTrckS: _____

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