

**ARIZONA VACCINES FOR CHILDREN (VFC)
PROGRAM 2022 PROVIDER AGREEMENT**

| FACILITY INFORMATION | | | |
|---|---------|----------------------------|---|
| Facility Name: | | | VFC Pin#: |
| Facility Address: | | | |
| City: | County: | State: | Zip: |
| Telephone: | | Fax: | |
| Shipping Address <i>(if different than facility address)</i> : | | | |
| City: | County: | State: | Zip: |
| MEDICAL DIRECTOR OR EQUIVALENT (M.D., D.O., NP or FNP) | | | |
| Instructions: <i>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.</i> | | | |
| Last Name, First, MI: | | Title: | Specialty: |
| License No.: | | Medicaid or NPI No.: | Employer Identification No. <i>(optional)</i> : |
| <i>Provide Information for second individual as needed:</i> | | | |
| Last Name, First, MI: | | Title: | Specialty: |
| License No.: | | Medicaid or NPI No.: | Employer Identification No. <i>(optional)</i> : |
| VFC VACCINE COORDINATOR | | | |
| Primary Vaccine Coordinator Name: | | | |
| Telephone: | | Email: | |
| Annual training requirements completion date: | | Type of training received: | |
| Back-Up Vaccine Coordinator Name: | | | |
| Telephone: | | Email: | |
| Annual training requirements completion date: | | 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:

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| 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. | <p>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:</p> <p>A. Federally Vaccine-eligible Children (VFC eligible)</p> <ol style="list-style-type: none">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. <p>B. State Vaccine-eligible Children</p> <ol style="list-style-type: none">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. <p>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.</p> |
| 3. | <p>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:</p> <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 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 six years 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. |

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| 6. | <p><u>VFC Vaccine Eligible Children</u></p> <p>I will not charge a vaccine administration fee to non-Medicaid federal vaccine eligible children that exceeds the administration fee cap of \$21.33 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.</p> <p>Non-VFC Vaccine Eligible Children</p> <p><u>I will not charge a vaccine administration</u> fee to non-Medicaid state vaccine eligible children that exceeds the administration fee cap of \$21.33 per vaccine dose.</p> |
| 7. | <p>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.</p> |
| 8. | <p>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).</p> |
| 9. | <p>I will comply with the requirements for vaccine management including:</p> <ul 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 Arizona Vaccines for Children 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. | <p>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:</p> <p>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.</p> <p>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.</p> |
| 11. | <p>I will participate in VFC program compliance site visits including unannounced visits, and other educational opportunities associated with VFC program requirements.</p> |
| 12. | <p>For providers with a signed deputization Memorandum of Understanding between a FQHC or RHC and the Arizona Immunization Program Office to serve underinsured VFC-eligible children, I agree to:</p> <ul style="list-style-type: none"> 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 <p>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.</p> |


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| 13. | <p>For pharmacies, urgent care, or school located vaccine clinics, I agree to:</p> <ul style="list-style-type: none"> 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. <p>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.</p> |
| 14. | <p>I will comply with all Arizona Immunization statutes and rules regarding childcare and school immunizations, and shall report all immunizations administered to children birth through 18 years of age to the Arizona Immunization Information System (ASIS) within 30 days of administration. ARS 36-135; ARS 36-374; R9-6-701-707; R9-5-304-305.</p> <p>I will be responsible for the actions of my staff regarding the confidentiality of information contained in the registry system. Staff will adhere to the requirements in the ASIS Confidentiality Policy, which is incorporated by reference into this agreement.</p> <p>I will submit immunization information to ASIS via direct data entry or electronic reporting. Paper reporting is no longer an available option.</p> |
| 15. | <p>I agree to replace vaccine purchased with state or federal funds (VFC, 317) that are deemed non-viable due to provider negligence on a <u>dose-for-dose</u> basis.</p> |
| 16. | <p>I understand this facility or the Arizona Vaccines for Children 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 Arizona Vaccines for Children Program.</p> |

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| <p><i>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.</i></p> | |
| <p>Medical Director or Equivalent Name (print):</p> | |
| <p>Signature:</p> | <p>Date:</p> |
| <p>Name (print) <i>Second individual as needed</i>:</p> | |
| <p>Signature:</p> | <p>Date:</p> |


**Arizona Vaccines for Children (VFC)
Refrigerator and Freezer Verification Form for 2022**

Please indicate the type of units your office is currently using to store VFC vaccines by initialing and listing the number of units in the correct box. The form shall be signed and initialized by the Medical Director or Equivalent (M.D., D.O., NP or FNP).

Name of Practice: _____

| | |
|---|--|
| <p>1) Stand-alone Refrigerator- <u>no freezer inside</u> OR A Commercial Refrigerator Unit</p> <p>I certify that I have a stand-alone refrigerator. _____ Initials _____ Number of units</p> | <p>VFC RECOMMENDED</p>  |
|---|--|

| | |
|--|---|
| <p>2) Stand-alone Freezer OR A Commercial Freezer Unit</p> <p>I certify that I have a stand-alone freezer. _____ Initials _____ Number of units</p> | <p>VFC RECOMMENDED</p>  |
|--|---|

| | |
|---|--|
| <p>3) Regular Household Refrigerator With 2 separate outside doors and 2 separate temperature controls</p> <p>I certify that I have a regular household refrigerator. _____ Initials _____ Number of units</p> |  |
|---|--|

Vaccine Statement

In addition to the above stated responses, please answer the following statements to verify that your facility is able to meet all of the VFC storage and handling requirements as outlined in the *VFC Operations Manual*.

| | |
|---|--|
| I have a continuous temperature monitoring device (data logger) in each of my storage units | Yes <input type="radio"/> No <input type="radio"/> |
| The freezer maintains a temperature of +5F (-15C) to -58F (-50C) | Yes <input type="radio"/> No <input type="radio"/> |
| Does this site store VFC vaccine in a dorm style or bar style refrigerator? | Yes <input type="radio"/> No <input type="radio"/> |

I certify that the above initialed unit(s) will be used to store VFC vaccine. I will record temperatures twice daily on a Temperature Log, using a certified and calibrated continuous temperature monitoring device with report capabilities (data logger). I also assume responsibility for the vaccines I order and agree to the dose for dose replacement of VFC vaccine doses that have expired or been wasted due to improper storage or failure to maintain proper temperatures.

Signature of Medical Director or Equivalent (M.D., D.O., NP or FNP)

Date

Arizona Vaccines for Children (VFC)

Program 2022 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 | | | | | | |
|---|--|----------------------|--|---|---|--|
| Provider's Name: | | | | | | |
| Facility Name: | | | | | | |
| VFC Contact: | | | | | | |
| Vaccine Delivery Site Street Address: | | | | | | |
| Delivery City: | Delivery State: | Delivery Zip: | | | | |
| Telephone: | Email: | | | | | |
| Fax: | Mailing Address or PO Box: | | | | | |
| City, State, Zip: | | | | | | |
| List office hours available to receive vaccine shipments (If the office is closed for lunch, enter the open hours for each day in the separate columns) | Monday | | | | | |
| | Tuesday | | | | | |
| | Wednesday | | | | | |
| | Thursday | | | | | |
| | Friday | | | | | |
| FACILITY TYPE (select facility/practice 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"/> School-Based Clinic <input type="checkbox"/> Teen Health Center <input type="checkbox"/> Adolescent Only Provider <input type="checkbox"/> Other _____ | <table style="width: 100%; border: none;"> <tr> <td style="width: 33%; padding: 2px; vertical-align: top;"> <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"/> Woman Infants and children <input type="checkbox"/> Other _____ </td> <td style="width: 33%; padding: 2px; vertical-align: top;"> <input type="checkbox"/> STD/HIV <input type="checkbox"/> Family Planning <input type="checkbox"/> Juvenile <input type="checkbox"/> Detention Center <input type="checkbox"/> Correctional Facility <input type="checkbox"/> Drug Treatment Facility <input type="checkbox"/> Migrant Health Facility <input type="checkbox"/> Refugee Health Facility <input type="checkbox"/> School-Based Clinic <input type="checkbox"/> Teen Health Center <input type="checkbox"/> Adolescent Only </td> <td style="width: 33%;"></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"/> Woman Infants and children <input type="checkbox"/> Other _____ | <input type="checkbox"/> STD/HIV <input type="checkbox"/> Family Planning <input type="checkbox"/> Juvenile <input type="checkbox"/> Detention Center <input type="checkbox"/> Correctional Facility <input type="checkbox"/> Drug Treatment Facility <input type="checkbox"/> Migrant Health Facility <input type="checkbox"/> Refugee Health Facility <input type="checkbox"/> School-Based Clinic <input type="checkbox"/> Teen Health Center <input type="checkbox"/> Adolescent Only | |
| <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"/> Woman Infants and children <input type="checkbox"/> Other _____ | <input type="checkbox"/> STD/HIV <input type="checkbox"/> Family Planning <input type="checkbox"/> Juvenile <input type="checkbox"/> Detention Center <input type="checkbox"/> Correctional Facility <input type="checkbox"/> Drug Treatment Facility <input type="checkbox"/> Migrant Health Facility <input type="checkbox"/> Refugee Health Facility <input type="checkbox"/> School-Based Clinic <input type="checkbox"/> Teen Health Center <input type="checkbox"/> Adolescent Only | | | | | |
| <p style="text-align: center;">Practice Type:</p> <input type="checkbox"/> Community Health Center <input type="checkbox"/> Family/General <input type="checkbox"/> Pediatrics <input type="checkbox"/> Other _____ | | | | | | |

PROVIDER POPULATION

Please provide an estimate of the patients that this location will see in a year that are VFC or non-VFC eligible.

Provider Population is 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. If you need assistance, please call the VFC Program Office at 602-364-3642.

| VFC Vaccine Eligibility Categories | # of children who received VFC Vaccine by Age Category | | | |
|---|--|-----|------|-------|
| | <1 Year | 1-6 | 7-18 | Total |
| Enrolled in Medicaid (AHCCCS) | | | | |
| No Health Insurance (Uninsured) | | | | |
| American Indian/Alaska Native | | | | |
| Total VFC: | | | | |
| Non-VFC Vaccine Eligibility Categories | # of children who received non-VFC Vaccine by Age | | | |
| | <1 Year | 1-6 | 7-18 | Total |
| Insured (private pay/health insurance covers vaccines) | | | | |
| Enrolled in CHIP (KidsCare) ¹ | | | | |
| Underinsured in non-deputized facility ² | | | | |
| Total Non-VFC: | | | | |
| Total Patients (must equal sum of Total VFC + Total Non-VFC) | | | | |

¹ CHIP (KidsCare) – 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.

² Underinsured - children with health insurance but the coverage does not include vaccines or the health insurance covers only selected vaccines. When an Underinsured child presents at a non-deputized provider, private vaccine stock is administered for the vaccines that are covered by health insurance. For the vaccines not covered by health insurance, the underinsured child is referred to a deputized provider office, CHD, FQHC or RHC to receive VFC vaccines or administered private vaccine stock and charged out-of-pocket.

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 Data | <input type="radio"/> Provider Encounter Data |
| <input type="radio"/> ASIIS | <input type="radio"/> Billing System |
| <input type="radio"/> Other (Please specify): | |

Add/Remove ASIIS Users

Please list the full name, email and select a user access level for additional staff member with access level changes or for removal. **Primary and Back-up coordinators will be assigned Coordinator Access by default.**

- **Access Level 0 – Remove User**
- **Access Level 1 – View Only Permissions** - can view patients and immunization records
- **Access Level 2 – Edit Permissions** - can view, add and make changes to patients and immunization records
- **Access Level 3 – Edit and Cold Storage** - can view, add and make changes to patients and immunization records; can access VOMS - Cold Storage.
- **Coordinator Access – Primary and Back-up Vaccine Coordinators** - can view, add and make changes to patients and immunization records; can process vaccine orders, reconciliation and access Cold Storage.

All users with Coordinator Access (Primary and Back-up Vaccine Coordinators) are required to complete an annual training (CDC-"You Call the Shots" or required AIPO Train modules) and include the Certificates when submitting this request.

| | Name | E-mail Address | Access Level |
|-----|------|----------------|--------------|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |
| 6. | | | |
| 7. | | | |
| 8. | | | |
| 9. | | | |
| 10. | | | |
| 11. | | | |
| 12. | | | |

All Users shall electronically accept the terms of the Pledge to Protect Confidential Information on their first login.

ASIIS is a computer based immunization registry and tracking system implemented by the Arizona Department of Health Services and its partners. It is intended to aid health care professionals and other users who have a need to check a client's immunization status according to A.R.S § 36-135, R9-6-707, and R9-6-708. Through ASIIS, providers can place orders for publicly funded vaccines to provide to children eligible to receive VFC vaccines. Client-specific information and vaccine ordering privileges are only available to authorized users and the Arizona Department of Health Services. The Users enters into this agreement with the Arizona Department of Health Services and agree to adhere to all requirements that are listed in the *Pledge to Protect Confidential Information* available on the ASIIS Main page.