VACCINES FOR CHILDREN PROGRAM PROVIDER AGREEMENT

FACILITY INFORMATION			
Facility Name:			VFC 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: *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.*

**Note: For the purposes of the VFC program, the term 'vaccine' is defined as any FDA-authorized or licensed, ACIP-recommended product for which ACIP approves a VFC resolution for inclusion in the VFC program.*

Last Name, First, MI:		Title:
Specialty:	License No:	Medicaid or NPI No:
Employer Identification Number:		Email:

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 practice administrator 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 a) 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 federal vaccine eligibility 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 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.	<u>VFC Vaccine Eligible Children</u> I will not charge a vaccine administration fee to non-Medicaid federal vaccine eligible children that exceeds the administration fee cap of $21.32 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. <u>Non-VFC Vaccine Eligible Children</u> I will not charge a vaccine administration fee to non-Medicaid state vaccine eligible children that exceeds the administration fee cap of $21.23 per vaccine dose.
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 Statement (VIS) (or Immunization Information Statement for nirsevimab) each time a vaccine is administered and maintain records in accordance with the National Vaccine Injury Compensation Program (VICP), which includes reporting clinically significant adverse events to the Vaccine Adverse Event Reporting System (VAERS). Note: *Until a COVID-19 Vaccine Information Statement (VIS) becomes available, provide information prior to vaccination as follows: EUA Fact Sheet for Recipients, Emergency Use Instructions (EUI), or BLA package insert, as applicable.* *For nirsevimab when not co-administered with other vaccines, report all suspected adverse reactions to MedWatch. Report suspected adverse reactions following co-administration of nirsevimab with any vaccine to the Vaccine Adverse Event Reporting System (VAERS).*
9.	I will comply with the requirements for vaccine management including: a) Order vaccine and maintain appropriate vaccine inventories; b) Not store vaccine in dormitory-style units at any time; c) Store vaccine under proper storage conditions at all times. Refrigerator and freezer vaccine storage units and temperature monitoring equipment and practices must meet Montana Immunization Program storage and handling recommendations and requirements; d) Return 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:** 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.

12.	I agree to replace vaccine purchased with state and federal funds (VFC, 317) that are deemed non-viable due to provider negligence on a dose-for-dose basis.
13.	For providers with a signed deputization Memorandum of Understanding between a FQHC or RHC and the Montana 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) Submit required deputization reporting 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 vaccinations, then the policy would apply to underinsured patients as well. "Walk-in" may also include VFC-eligible newborn infants at a birthing facility.*
14.	For specialty providers, such as pharmacies, urgent care, school-located vaccine clinics, or birthing hospitals, 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 vaccinations, then the policy would apply to VFC patients as well. "Walk-in" may also include VFC-eligible newborn infants at a birthing facility.*
15.	I understand this facility or the Montana 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 Montana 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:

ADDITIONAL PROVIDERS

PROVIDERS PRACTICING AT THIS FACILITY *(attach additional pages as necessary)*				
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**