

Provider/Practice Name _____

(Please Print Full Name)

Health Care Providers: Each provider site registered with the NYS Immunization Program to receive vaccine for Vaccines for Children (NYS VFC) and Child Health Plus B (CHPlus B) eligible children must complete this form (to be updated annually). The information supplied by you will enable the NYS Immunization Program to (a) determine the level of vaccine supplies required and (b) charge the appropriate government funding source. This form must be completed by one provider for each group practice.

PLEASE CHECK ONLY ONE (1) BOX AS IT APPLIES TO YOUR PRACTICE TYPE.

Hospital Diagnostic & Treatment Center _____
(Please Print Full Name of Parent Facility)

College/School Health Program (CIRCLE ONE)

Satellite Clinic (of _____ Hospital or Facility)
(Please Print Full Name of Parent Facility)

Other Type of Facility _____
(Please Print Full Name)

Solo (Private) Practice (Owned by one MD, with only one MD on staff; may include nurse practitioners, RNs or physician's assistants).

Group Practice (Owned by one MD or a Group of MDs)

Provider Specialty _____
(Please Print Specialty Type)

ANNUAL PATIENT NUMBERS

This section must be completed for registration with the NYS VFC Program in order to receive free vaccine for NYS VFC and CHPlus B eligible children in your practice. Registration will be delayed if this section is not completed.

PROJECTED NUMBER of children in each category that will receive vaccinations at your practice for the next twelve months. NOT PERCENTAGES	0-<12 months of age	1-6 years of age	7-18 years of age (up to 19th birthday)
• Medicaid/Medicaid Managed Care Enrolled			
• Not Insured			
• American Indian/Alaskan Native			
• Underinsured not eligible under the above categories. (Health insurance <i>does not</i> pay for vaccines)			
• Child Health Plus B (CHPLUS B)			
TOTAL ALL COLUMNS			

HEALTH CARE PROVIDER: In order to receive vaccine provided at no cost for Vaccines for Children and Child Health Plus B eligible patients, provider(s) enrolling with the NYS Immunization Program must agree to the following conditions.

1. I agree that vaccine supplied by the New York State Immunization Program will be administered only to a child < 19 years of age who:(1) is enrolled in Medicaid/Medicaid Managed Care (2) has no insurance (3) is an American Indian or Alaskan Native (4) is underinsured (health insurance does not pay for vaccines), or (5) is enrolled in Child Health Plus B (CHPlus B).
2. I will maintain patient eligibility screening records and temperature log sheets for a period of at least three years. If requested, I will make such records available to the New York State Department of Health and/or the U.S. Department of Health and Human Services (DHHS).
3. I will participate in VFC site visits conducted by a VFC representative, including any follow-up visits that may be required.
4. I will participate in assessments of my practice's immunization levels including any follow-up visits. CDC software will be utilized at the time of the assessments.
5. I will comply with the appropriate immunization schedule, age, dosage, 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, b) The particular requirements are not in compliance with the law of NYS, including State laws relating to religious or other exemptions.
6. As mandated by Federal Law 42 U.S.C. § 300aa-25 and 42 U.S.C. § 300aa-26, I will distribute the most current Vaccine Information Statements (VIS) each time a vaccine is administered and maintain records in accordance with the National Childhood Vaccine Injury Compensation Act (NCVIA) which includes reporting clinically significant adverse events to the Vaccine Adverse Event Reporting System (VAERS).
7. I will not impose a charge for the cost of vaccines administered to NYS VFC and CHPlus B eligible children.
8. A NYS administration fee cap per vaccine in an amount no higher than \$17.85 may be charged to all non-Medicaid eligible children. The current Medicaid fee for service administration fee reimbursement is \$17.85. Medicaid Managed Care and Child Health Plus B administration fees are negotiated under contracts with the insurers.
9. I will not deny administration of a VFC supplied vaccine to any NYS VFC or CHPlus B child due to the inability of the child's parent or guardian to pay the vaccine administration fee.
10. I will comply with the State's requirements for ordering vaccine, for reporting vaccine usage, spoilage, expiration and physical inventories and all other requirements as outlined on the enclosed forms. I agree to operate within the VFC program in a manner intended to avoid fraud and abuse.
11. I will accept the responsibility to maintain the integrity of the vaccines in accordance with package inserts.
12. I will be responsible for returning all publicly purchased vaccines to NY State in accordance with instructions. Call 1-800-KID-SHOT(S) - 1-800-543-7468 to return any unused (wasted or expired) vaccines.
13. I understand that the State or the provider may terminate this agreement at any time for personal reasons or failure to comply with these requirements. If the provider chooses to terminate the agreement, he or she agrees to properly return any unused VFC vaccine.
14. I will not refer any VFC/CHPlus B eligible children to local county health units to receive any vaccines available through this program.

Enrollment cannot be processed without signing the following page of this Provider Agreement.

