Iowa Department of Public Health
Vaccines for Children Program
Provider Enrollment Form

Facility Name: _____

Facility Address: _____

Telephone: _____ **Fax:** _____

Medical Director or Equivalent

1) _____ _____ _____ _____
Last Name, First, M.I. Medical License No. Title (MD, DO, NP, PA) Medicaid/NPI No.

2) _____ _____ _____ _____
Last Name, First, M.I. Medical License No. Title (MD, DO, NP, PA) Medicaid/NPI No.

Providers Practicing at this Facility (all additional providers within the practice must be listed here)

1) _____ _____ _____ _____
Last Name, First, M.I. Medical License No. Title (MD, DO, NP, PA) Medicaid/NPI No

2) _____ _____ _____ _____
Last Name, First, M.I. Medical License No. Title (MD, DO, NP, PA) Medicaid/NPI No.

3) _____ _____ _____ _____
Last Name, First, M.I. Medical License No. Title (MD, DO, NP, PA) Medicaid/NPI No.

4) _____ _____ _____ _____
Last Name, First, M.I. Medical License No. Title (MD, DO, NP, PA) Medicaid/NPI No.

5) _____ _____ _____ _____
Last Name, First, M.I. Medical License No. Title (MD, DO, NP, PA) Medicaid/NPI No.

6) _____ _____ _____ _____
Last Name, First, M.I. Medical License No. Title (MD, DO, NP, PA) Medicaid/NPI No.

VFC Vaccine Manager Name: _____

_____ _____
Phone Email

Back-Up VFC Vaccine Manager Name: _____

_____ _____
Phone Email

☐ VFC Vaccine Manager has completed the annual training requirements (Completion of the CDC web-based modules, *VFC Requirements: You Call the Shots* and *Storage and Handling: You Call the Shots,* will satisfy education requirement)

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 healthcare facility of which I am the medical director or practice administrator or equivalent:

1. I will screen patients and document eligibility status at each immunization encounter for VFC eligibility and administer VFC-purchased vaccine only to children who are 18 years of age or younger who meet one or more of the following categories:
   a. are an American Indian or Alaska Native
   b. are enrolled in Medicaid
   c. have no health insurance
   d. 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.

   Children ***not*** eligible for VFC-purchased vaccine: Underinsured children seen at local public health agencies (LPHAs) are considered state vaccine eligible for administration of pediatric vaccines purchased with Section 317 or state funds when a signed Memorandum of Understanding between a RHC and the LPHA has not been executed.

2. 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;
   b. The particular requirements contradict state law, including laws pertaining to religious and other exemptions.

3. I will maintain all records related to the VFC program for a minimum of three years, or longer if required by state law, and make these records available to public health officials, including the state or Department of Health and Human Services, (DHHS) upon request.

4. I will immunize eligible children with VFC-supplied vaccine at no charge to the patient for the vaccine.

5. I will not charge a vaccine administration fee to non-Medicaid VFC-eligible children that exceeds the administration fee cap of $19.68 per vaccine dose. For Medicaid VFC-eligible children, I will accept the reimbursement for immunization administration set by the state Medicaid agency or the contracted Medicaid health plans.

6. I will not deny administration of a federally purchased vaccine to an established patient because the child's parent/guardian/individual of record is unable to pay the administration fee.

7. 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).

8. I will comply with the requirements for vaccine ordering, vaccine accountability, and vaccine management. Agree to operate within the VFC program in a manner intended to avoid fraud and abuse. VFC providers may not store federally purchased vaccine in dormitory style refrigerators at any time. Return all spoiled/expired public vaccines to CDC's centralized vaccine distributor within six months of spoilage/expiration.

9. I will participate in VFC program compliance site visits, storage and handling unannounced visits, and other educational opportunities associated with VFC program requirements.

10. I will comply with requirements as determined by Iowa Immunization Program for vaccine ordering, patient screening, and usage reporting associated with state vaccine program.

11. For the local public health agencies with a signed Memorandum of Understanding between a RHC and the state immunization program to serve underinsured VFC-eligible children, I agree to:
    - Include "underinsured" as a VFC eligibility category during the screening for VFC eligibility at every visit;
    - Vaccinate "walk-in" VFC-eligible underinsured children and
    - Report required usage data

12. For Specialty Providers (identified as pharmacies, urgent care, or school located vaccine clinics), I agree to vaccinate all "walk-in" VFC-eligible children and will not refuse to vaccinate VFC-eligible children based on a parent's inability to pay the administration fee.

13. I agree to be held financially responsible for the replacement cost of vaccine that cannot be accounted for, that is wasted, stored inappropriately, or is deemed non-viable due to failure of this clinic to comply with established storage and handling guidelines or otherwise failure to comply with this agreement. The IDPH will determine violations by evaluating each case.

14. I understand this facility or the state/local immunization program may terminate this agreement at any time for personal reasons or failure to comply with these requirements. If I choose to terminate this agreement, I will properly return any unused VFC vaccine.

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 for compliance with these requirements.

Medical Director or Equivalent Signature: _____

Date: _____