



# VFC PROVIDER ENROLLMENT FORM

**PHILADELPHIA DEPARTMENT OF PUBLIC HEALTH  
DDC/ VACCINES FOR CHILDREN PROGRAM  
500 S. BROAD ST, 2<sup>nd</sup> Floor, PHILADELPHIA, PA 19146  
Phone: 215-685-6748 / Fax: 215-238-6948**

FACILITY NAME:	VFC PIN #:		
ADDRESS:	CITY:	STATE:	ZIP CODE:
PHONE NUMBER:	FAX NUMBER:		
EMPLOYER IDENTIFICATION NUMBER:	MEDICAL LICENSE NUMBER:		

In order to participate in the Vaccines for Children (VFC) program and/or to receive other federally procured vaccine provided to me at no cost, I, on behalf of myself and any and all practitioners associated with this medical office, group practice, Health Maintenance Organization, health department, community/migrant/rural clinic, or other entity of which I am physician-in-chief or the equivalent, agree to the following:

- I will screen patients at all immunization encounters for VFC eligibility and administer VFC-purchased vaccine only to children who are 18 years of age or younger who: (a) are enrolled in Medicaid (or qualifies through a state's Medicaid waiver), or (b) have no health insurance, or (c) are an American Indian or Alaskan Native, or (d) are underinsured, i.e. has commercial (private) health insurance but coverage does not include vaccines, only covers selected vaccines, or caps vaccine coverage at a certain amount (underinsured patients are only eligible to receive vaccines administered by or on behalf of a FQHC). SCHIP patients are NOT eligible to receive VFC vaccines.
- I will comply with the 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 making a medical judgment, and in accordance with accepted medical practice, I deem such compliance to be medically inappropriate, or (b) the particular requirement is not in compliance with Pennsylvania state law, including the laws pertaining to religious and philosophical exemptions.
- I will maintain records related to the VFC program for a minimum of 3 years and if requested will make such records available to the City of Philadelphia, State of Pennsylvania, or the Department of Health and Human Services. Release of such records will be bound by the privacy protection of Federal Medicaid law.
- I will immunize eligible children with VFC-supplied vaccine at no charge to the patient for the vaccine.
- I will not charge a vaccine administration fee to non-Medicaid VFC-eligible children that exceeds the Pennsylvania administration fee cap of \$15.76 per vaccine dose. For Medicaid VFC-Eligible children, I will accept the reimbursement for immunization administration set by contracted Medicaid health plans.
- I will not deny the administration of federally purchased vaccine to an established patient because the child's parent/guardian/individual of record is unable to pay the administration fee.
- I will distribute the most current versions of the Vaccine Information Statements (VIS) each time a vaccine is administered and maintain records in accordance with the National Childhood Vaccine Injury Compensation Act (NCVICA), which includes reporting clinically significant adverse events to the Vaccine Adverse Event Reporting System (VAERS).
- I will comply with the Philadelphia Department of Public Health's (PDPH) requirements for ordering vaccine, vaccine accountability, and vaccine management, and to operate within the VFC program in a manner intended to avoid fraud and abuse as outlined in the Philadelphia VFC Manual.
- The PDPH or I may terminate this agreement at any time for personal reasons or failure to comply with these requirements. If I choose to terminate the agreement, I agree to properly return any unused VFC vaccine within one week of termination. I also understand that I may not refer children who are Medicaid enrolled to my providers site to the District Health Centers for vaccines.
- I understand that immunization administration is a reportable event as per the Philadelphia Health Code § 6-210. I will make information on immunizations administered to children 0-18 years available to the Division of Disease Control's KIDS Registry. I also understand that I risk not receiving VFC vaccines if my office does not report immunizations in a timely manner.
- I will abide by all appropriate protocols for the storage and handling of immunobiologics as specified by the Philadelphia Department of Public Health.
- I agree to comply with the Philadelphia Department of Public Health VFC program announced and unannounced site visits. These visits include storage and handling visits and visits as it pertains to the Immunization Outreach Program.

<b>PRINT NAME of VFC Responsible Practitioner (Physician-In-Chief or equivalent):</b>	<b>TITLE:</b>
<b>SIGNATURE:</b>	<b>DATE:</b>

For PDPH Use Only

Vacman ID# \_\_\_\_\_ Date Certified for VFC \_\_\_\_\_ VFC Effective Date \_\_\_\_\_