Vaccines for Adults at Risk
VFAAR Program Enrollment

Department of Public Health
CITY OF PHILADELPHIA
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VFAAR PROGRAM PROVIDER AGREEMENT

FACILITY

Facility Name			VFAAR PIN
Facility Address			
City	County	State	Zip Code
Phone Number		Fax Number	
Shipping Address *(if different than facility address)*			
City	County	State	Zip Code

MEDICAL DIRECTOR OR EQUIVALENT

Instructions: *The official VFAAR registered healthcare provider signing the agreement must be a practitioner authorized to administer vaccines under state law who will also be held accountable for compliance by the entire organization and its VFAAR providers with the responsible conditions outlines in the provider enrollment agreement. The individual listed here must sign the provider agreement.*

Last Name, First, MI	Title	Speciality
License #	Medicaid or NPI #	Employer ID #

VFAAR VACCINE COORDINATOR

Primary Vaccine Coordinator Name	
Phone Number	Email
Completed "You Call the Shots" module? ☐ Yes ☐ No	CE Code
Back-up Vaccine Coordinator Name	
Phone Number	Email
Completed "You Call the Shots" module? ☐ Yes ☐ No	CE Code

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Office Hours *(Indicate lunch hours only if closed during lunch and unable to accept packages)*				
Monday	Tuesday	Wednesday	Thursday	Friday
Lunch	Lunch	Lunch	Lunch	Lunch

Type of Clinic *(choose one)*

☐ HIV Treatment Center ☐ Methadone Clinic/Detox Center ☐ Federally Qualified Health Center (FQHC)
☐ OESS ☐ Hospital ☐ OB Clinic ☐ Other:____________

PATIENT DATA

Use patient data for exact numbers on patient totals, and estimate the number of patients in the age ranges who will receive immunizations at your practice or for a 12-month period:	**Ages** (Do not count a patient in more than one category)				TOTAL
	19 - 26	27 - 49	50 - 64	65+	
Total VFAAR Population					
Non-VFAAR Eligible Patients (insured with any type of insurance)					

Type of Data Used for Patient Totals Above *(choose one)*

☐ Provider Encounter Data ☐ Medical Claims Data
☐ Doses Administered ☐ Other:____________________________________

VACCINE STORAGE UNITS

Indicate your **REFRIGERATOR** storage unit types below:

Type:
☐ Small/under counter* ☐ Combination ☐ Stand alone refrigerator
☐ Commercial/pharmacy grade
Number of Units:_________ Storage Capacity in Cubic Feet:_________

Type:
☐ Small/under counter* ☐ Combination ☐ Stand alone refrigerator
☐ Commercial/pharmacy grade
Number of Units:_________ Storage Capacity in Cubic Feet:_________

**Dormitory style units are not acceptable for vaccine storage.*

Primary **THERMOMETER** Type:
☐ Digital with Glycol-encased Probe ☐ Data-logger ☐ None
☐ Other:_________________ Date of Last Calibration:____________

Back-up **THERMOMETER** Type:
☐ Digital with Glycol-encased Probe ☐ Data-logger ☐ None
☐ Other:_________________ Date of Last Calibration:____________

Indicate your **FREEZER** storage unit types below:

Type:
☐ Small/under counter* ☐ Combination ☐ Stand alone freezer
☐ Commercial/pharmacy grade
Number of Units:_________ Storage Capacity in Cubic Feet:_________

Type:
☐ Small/under counter* ☐ Combination ☐ Stand alone freezer
☐ Commercial/pharmacy grade
Number of Units:_________ Storage Capacity in Cubic Feet:_________

Primary **THERMOMETER** Type:
☐ Digital with Glycol-encased Probe ☐ Data-logger ☐ None
☐ Other:_________________ Date of Last Calibration:____________

Back-up **THERMOMETER** Type:
☐ Digital with Glycol-encased Probe ☐ Data-logger ☐ None
☐ Other:_________________ Date of Last Calibration:____________

The information supplied on this form is complete and accurate to the best of my knowledge. I understand that this information will be used to determine the amount of vaccine needed by my practice and agree to submit an updated profile if there are changes in: the number of eligible patients seen, the status of the practice, vaccine contact or shipping information.

Signature	Date	VFAAR PIN

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VFAAR PIN

Instructions: *List below all licensed healthcare providers (MD, DO, NP, PA, pharmacist) at your facility who have prescribing authority.*

PROVIDERS PRACTICING AT THIS FACILITY

Provider Name	Title	License No.	Medicaid or NPI No.	EIN *(Optional)*

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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 healthcare facility of which I am the medical director 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 patients 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 VFAAR eligibility (i.e. federally or state vaccine-eligible) and administer VFAAR-purchased vaccine only to patients who are uninsured or underinsured and 19 years and older.
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 VFAAR program unless: 1. In the provider's medical judgement, and in accordance with accepted medical practice, the provider deems such compliance to be medically inappropriate for the patient. 2. The particular requirements contradict state law, including laws pertaining to religious and other exemptions.
4	I will maintain all records related to the VFAAR program for a minimum of three years and upon request make these records available for review. VFAAR records include, but are not limited to, VFAAR 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 patients with publicly supplied (VFAAR) vaccine at no charge to the patient for the vaccine.
6	**VFAAR Vaccine Eligible Patients** I will not charge a vaccine administration fee to federal vaccine (VFAAR) eligible patients that exceeds the administration fee cap of $23.14 per vaccine dose.
7	I will not deny administration of a publicly purchased vaccine to an established patient because the patient or patient's guardian/individual of record is unable to pay the administration fee.
8	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).
9	I will comply with the requirements for vaccine management including: 1. Ordering vaccine and maintaining appropriate vaccine inventories. 2. Not storing vaccine in dormitory-style units at any time. 3. Storing vaccine under proper storage conditions at all times. Refrigerator and freezer vaccine storage units and temperature monitoring equipment and practices must meet Philadelphia Department of Public Health's Immunization Program storage and handling requirements. 4. Returning all spoiled/expired public vaccines to CDC's centralized vaccine distributor within six months of spoilage/expiration.

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PROVIDER AGREEMENT	
10	I agree to operate within the VFAAR 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 VFAAR Program: **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. **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 healthcare. It also includes recipient practices that result in unnecessary cost to the Medicaid program.
11	I will participate in VFAAR program compliance site visits including unannounced visits, and other educational opportunities associated with VFAAR program requirements.
12	I agree to replace vaccine purchased with federal funds (VFAAR, 317) that are deemed non-viable due to provider negligence on a **dose-for-dose** basis.
13	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 all patients available to the Division of Disease Control's KIDS Plus IIS.
14	I understand this facility or Philadelphia Department of Public Health's 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 Philadelphia Department of Public Health's 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 Adults at Risk 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)	VFAAR PIN
Signature	Date

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RECENT STORAGE & HANDLING REQUIREMENTS

The VFAAR Program recently updated Storage & Handling policies.

- The VFAAR Program now requires all VFAAR vaccine storage units to be monitored by a certified, calibrated digital data logger.
- The VFAAR Program now requires all VFAAR providers to have a back-up thermometer.
- The VFAAR Program no longer allows VFAAR vaccine to be stored in the freezer unit of a household combination refrigerator/freezer. VFAAR vaccine previously stored in a combination refrigerator/freezer unit must be stored in stand-alone freezer units.

These policies effective now.

By signing this form, I verify that I have read the STORAGE & HANDLING UPDATE, I understand the VFAAR storage & handling policies listed above, and acknowledge that I am responsible for compliance with these requirements.

Medical Director or Equivalent Name (print)	VFAAR PIN
Signature	Date

Fax the complete VFAAR enrollment packet to 215-238-6948