

## Florida Vaccines for Children (VFC) Program 2013 Provider Initial Enrollment Form

**Instructions for applying to the Florida VFC Program:**

1. Complete this form. You may also submit this form electronically via our website at [http://www.immunizeflorida.org/vfc/provider\\_enrollment\\_form.htm](http://www.immunizeflorida.org/vfc/provider_enrollment_form.htm).
2. Fax or mail your application to:  
 Florida Vaccines for Children (VFC) Program  
 4052 Bald Cypress Way, Bin A-11, Tallahassee, FL 32399-1700  
 Fax: (850) 245-4734
3. Once your application has been reviewed and approved, a representative will contact you to schedule an onsite visit to evaluate project details and requirements, and to verify your refrigerator storage unit. *All providers must comply with Vaccine Storage Equipment Requirement prior to participating in the VFC Program. I agree to the following:*
  - I have a certified, calibrated thermometer.
  - I have a stand-alone, two-door refrigerator/freezer or equivalent unit.
  - I will notify the VFC Program when the VFC Program coordinator, who is responsible for vaccine management, changes.

Provider Profile Section			
NAME OF PHYSICIAN'S OFFICE, PRACTICE, OR CLINIC		ASSIGNED VFC PIN ( <i>Office Use Only</i> )	
Vaccine Delivery Information		Mailing Information	
VACCINE DELIVERY ADDRESS (Number/Street - <i>No P.O. Boxes</i> )		MAILING ADDRESS ( <i>if different from shipping information</i> )	
CITY	ZIP CODE	CITY	ZIP CODE
TELEPHONE NUMBER		FAX NUMBER	
VFC Program Coordinator*: (required)		EMAIL ADDRESS	
Back-Up VFC Program Coordinator*: (required)		EMAIL ADDRESS	
Check the one provider category that best describes you:			
<input type="checkbox"/> Doctor's Clinic <input type="checkbox"/> Hospital Clinic <input type="checkbox"/> County Health Department <input type="checkbox"/> FQHC (Federally Qualified Health Center) <input type="checkbox"/> Birthing Hospital		<input type="checkbox"/> Indian Tribes <input type="checkbox"/> School Clinic <input type="checkbox"/> Community Health Center <input type="checkbox"/> Juvenile Correctional Center <input type="checkbox"/> Other (specify):	

\*The VFC Program Coordinator and the Back-Up VFC Program Coordinator will be assigned ordering and inventory permissions for this VFC Program PIN within the Florida SHOTS account.

In order to participate in the Vaccines for Children (VFC) Program and/or to receive other publicly funded vaccine provided to me at no cost, I, on behalf of myself and all practitioners associated with this medical office, group practice, health maintenance organization, health department, community/rural clinic, or other entity of which I am the medical director or equivalent, agree to the following conditions:

1. Screen patients and document eligibility status at all immunization encounters for eligibility and administer VFC Program-purchased vaccine only to children who are 18 years of age or younger, and meet one or more of the following categories:
  - a. Federally vaccine-eligible
    - (1) American Indian or Alaskan Native
    - (2) Enrolled in Medicaid
    - (3) Has no health insurance
    - (4) Underinsured: Children who have commercial (private) health insurance but the coverage does not include vaccines, children whose insurance covers only selected vaccines (VFC Program-eligible for non-covered vaccines only), or children whose insurance caps vaccine coverage at a certain amount—once that coverage amount is reached, these children are categorized as underinsured. Underinsured children are eligible to receive VFC Program vaccine only through a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) or under an approved deputization agreement.
2. Comply with immunization schedule, dosage, and contraindications that are established by the 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 those pertaining to religious and other exemptions.
3. Maintain all records related to the VFC Program for a minimum of three (3) years and make these records available to public health officials, including the state or Department of Health and Human Services (DHHS) upon request.
  4. Immunize eligible children with VFC Program-supplied vaccine at no charge for the vaccine to the patient or parent.
  5. Not charge a vaccine administration fee to the non-Medicaid VFC Program-eligible children that exceed the administration fee cap of \$24.01 per vaccine dose. For Medicaid VFC Program-eligible children, accept the reimbursement for immunization administration set by the state Medicaid agency or the contracted Medicaid health plans.
  6. 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. Distribute the 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. 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 Program 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 (6) months of spoilage/expiration. I assume responsibility for the proper handling and storage of VFC Program-provided vaccine after delivery to my facility and understand that I may have to pay for vaccine wastage due to neglect.
  9. Participate in VFC Program compliance site visits, storage and handling unannounced visits, and other educational opportunities associated with VFC Program requirements.
  10. Pharmacists who enroll as VFC Program providers must have staff with statutory authority to immunize available and cannot refuse to vaccinate VFC Program-eligible children based on the parent's inability to pay the administration fee.
  11. Enroll in the Florida State Health Online Tracking System (SHOTS), the statewide immunization registry, in order to place vaccine orders. Participation in Florida SHOTS will facilitate direct ordering of vaccine by VFC Program providers in the future. If you do not have a Florida SHOTS account, complete an enrollment form online at <https://www.flshots.com/flshots/enroll/applicantquestions.html>. If you do not know if you have a Florida SHOTS account, contact the Florida SHOTS help desk at 1 (877) 888-7468.
  12. The VFC Program 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 Program vaccine.

**All providers must comply with Vaccine Storage Equipment Requirement prior to participating in the VFC Program. Providers are required to have certified, calibrated thermometers, and stand-alone, two-door refrigerator/freezer units.**

Signature: \_\_\_\_\_  
 Medical Director or equivalent  
 (Medical Doctor (MD), Doctor of Osteopathy (DO), Nurse Practitioner (NP), Physician Assistant (PA), Pharmacist (PharmD))

Name (Print) \_\_\_\_\_ Date: \_\_\_\_\_

Medical License Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

**Delivery Information Section**

**Delivery Instructions:** Between the hours of 8 a.m. and 5 p.m., your local time, write the **days of the week and times you may receive vaccine deliveries:**

Day of the Week	Open Time	Closed Time
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		

**LUNCH TIME:** \_\_\_\_\_

**Please Note:** It is the provider’s responsibility to notify the VFC Program in advance if the office will be closed during the days and times which are normally open for business. You can reach a VFC Program representative at (800) 483-2543, option 6.

**VFC Program Eligibility Section**

In a 12-month period, **estimate** the number of VFC Program children, by age and eligibility, which will be immunized at this location. (For example, 3 in the “< 1 year old” category, 4 in the “1-6 years old” category, and 2 in the “7-18 years old” category, total 9.)

(Note: Do not count a child in more than one category.)

VFC Program Eligibility	A <1 Year	B 1-6 Years	C 7-18 Years	(A+B+C) Total
Enrolled in Medicaid				
Uninsured				
American Indian/Alaskan Native Underinsured/FQHC*				
(has health insurance but it does not cover immunizations)				
Not Eligible**				
<b>Total</b>				

\*To be VFC Program-eligible, underinsured children must be vaccinated through a FQHC, RHC, or under an approved deputization agreement.

\*\*These children are *not* eligible for VFC Program vaccines.

<b>Vaccine Management in Florida SHOTS Section</b>				
List personnel, in addition to the VFC Program Coordinator and the Back-Up VFC Program Coordinator, and place a checkmark for the requested permissions to manage and order your VFC Program vaccine in Florida SHOTS. All personnel must have a Florida SHOTS User ID to access VFC Program functionality. System User IDs can only be created by your local organization administrator or the Florida SHOTS help desk. Contact the Florida SHOTS help desk at (877) 888-7468.				
Personnel Name	Florida SHOTS System User ID [Yes/No]	Update Inventory (Apply Pending Receipts to Inventory)	Can See Orders (View Only for Order Status)	Can Update Orders (Create/Modify VFC Program Vaccine Order Requests)

<b>Provider List Section</b>					
<b>List of Health Care Providers Licensed to Administer Vaccines</b>					
<i>Instructions: Use this form to list all health care providers at your facility licensed to administer vaccines. Use a separate sheet of paper, if additional space is necessary, and attach to the original document.</i>					
Last Name, First, MI	Medical License Number	Medicaid Number	National Provider ID (NPI)	Title (MD, DO, NP, PA)	Specialty (Peds, Family Med, Other)

<b>FOR OFFICE USE ONLY</b>			
Designated Ordering Tier	Classification		
<input type="checkbox"/> M1, <input type="checkbox"/> M2 <input type="checkbox"/> B1, <input type="checkbox"/> B2, <input type="checkbox"/> B3, <input type="checkbox"/> B4 <input type="checkbox"/> Q1, <input type="checkbox"/> Q2, <input type="checkbox"/> Q3, <input type="checkbox"/> Q4, <input type="checkbox"/> Q5, <input type="checkbox"/> Q6			