NEBRASKA

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

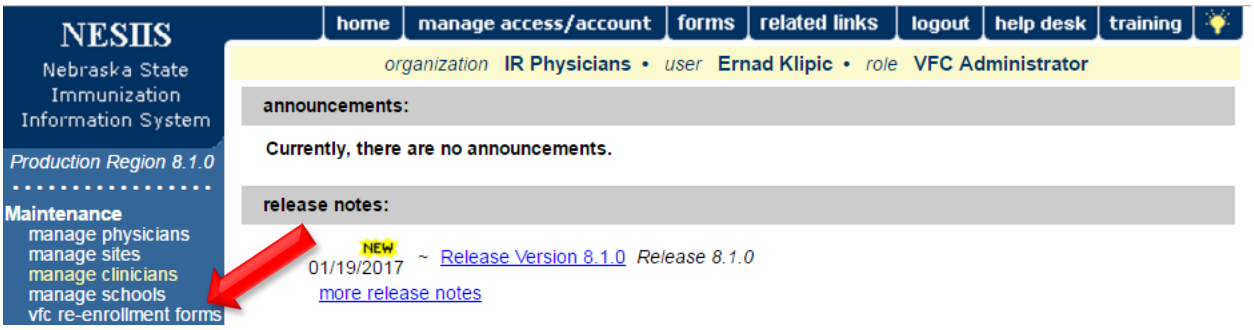
Pete Ricketts, Governor

VFC Providers

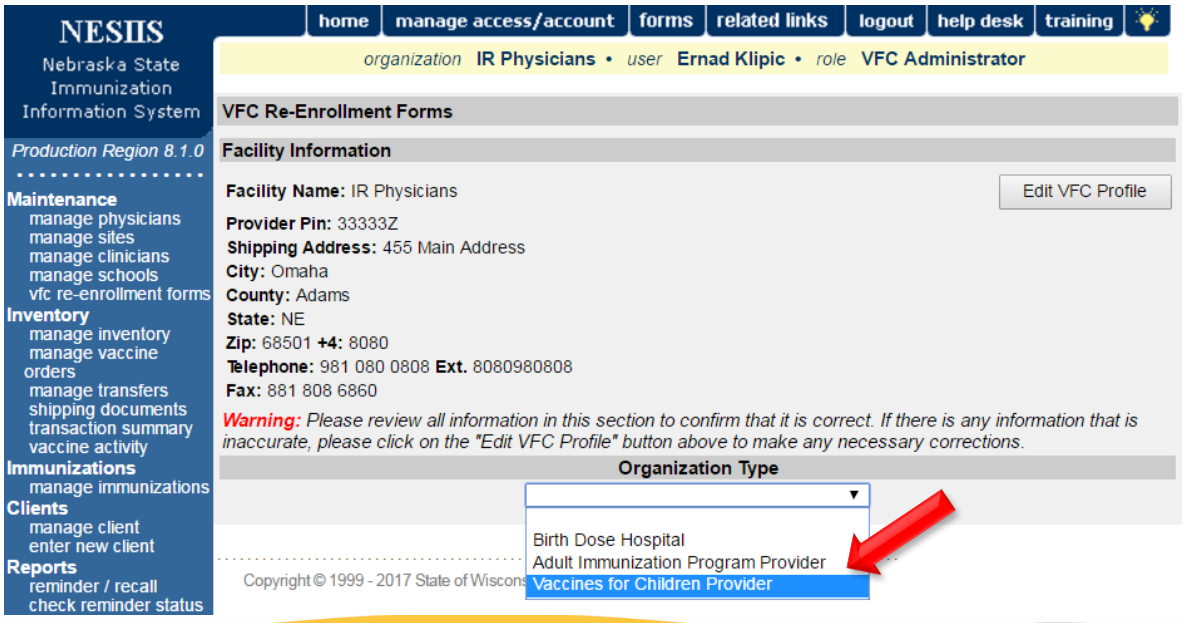
VFC Provider Enrollment Agreement

These directions are intended to provide step-by-step instructions for completing the Vaccines for Children (VFC) Program's annual re-enrollment, which is required for all participating VFC providers.

1. Click on the "**VFC RE-ENROLLMENT FORMS**":



2. Please review all information in this section to confirm that it is correct. If there is any information that is inaccurate, please click on the "**Edit VFC Profile**" button above to make any necessary corrections. Then, in the dropdown list under "Organization Type", select **VACCINE FOR CHILDREN:**



3. All fileds in **blue** are required:

Organization Type

Vaccines for Children Provider

Facility Address (if different than Shipping Address)

Facility Address:

City:

County:

Zip: +4:

Medical Director or Equivalent

*Last Name: Jackson

*First Name: Sandra

Middle Initial:

*Title: MD

Specialty: 145787

*Medical License Number: 25421256

*Medicaid/NPI Number: 3251214

VFC Vaccine Coordinator

Primary Vaccine Coordinator

*Last Name: Roberts

*First Name: Rachel

Middle Initial:

* Telephone: 402 322 5478 Ext.:

Email: rachel.roberts@pharmacy.com

*Have you read and signed the NE Immunization Program Provider Manual in the past 12 months? Yes

*What additional training related to immunizations have you completed in the past 12 months?

- [ ] Attended Previous Year VFC Site Visit
- [ ] Completed CDC You Call the Shots Module
- [x] Completed CDC Pink Book Training
- [x] Attended an Immunization Conference
- [ ] N/A- Did Not Complete Additional Training
- [ ] Other

4. List all licensed health care providers (MD, DO) at your facility who have prescribing authority. Provide title, license #, and Medicaid/NPI #. The Employee Identification Number (EIN) is optional. Then click **ADD** button:

Providers Practicing at this Facility

*Last Name:

Add

*First Name:

Middle Initial:

*Medical License Number:

*Title: MD

*Medicaid/NPI Number:

EIN:

5. Please read the agreement carefully and make sure you fully understand its contents.

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:

- I will annually submit a provider profile representing populations served by my practice/facility. I will submit more frequently if
  - the number of children served changes or
  - the status of the facility changes during the calendar year.
- I will screen patients and document eligibility status at each immunization encounter for VFC eligibility (i.e., federally or state vaccine-eligible) and administer VFC-purchased vaccine by such category only to children who are 18 years of age or younger who meet one or more of the following categories:
  - Federally Vaccine-eligible Children (VFC eligible)
    - Are an American Indian or Alaska Native;
    - Are enrolled in Medicaid;
    - Have no health insurance;
    - 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.
  - State Vaccine-eligible Children
    - In addition, to the extent that my state designates additional categories of children as "state vaccine-eligible", I will screen for such eligibility as listed in the addendum to this agreement and will administer state-funded doses (including 317 funded doses) to such children.
      Children aged 0 through 18 years that do not meet one or more of the eligibility federal vaccine categories (VFC eligible), are not eligible to receive VFC-purchased vaccine.
- 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 VFC program unless:
  - In the provider's medical judgment, and in accordance with accepted medical practice, the provider deems such compliance to be medically inappropriate for the child;
  - The particular requirements contradict state law, including laws pertaining to religious and other exemptions.
- I will maintain all records related to the VFC program for a minimum of three years and upon request make these records available for review. VFC records include, but are not limited to, VFC screening and eligibility documentation, billing records, medical records that verify receipt of vaccine, vaccine ordering records, and vaccine purchase and accountability records.
- I will immunize eligible children with publicly supplied vaccine at no charge to the patient for the vaccine.
- I will not charge a vaccine administration fee to non-Medicaid federal vaccine eligible children that exceeds the administration fee cap of $19.82 per vaccine dose. For Medicaid children, I will accept the reimbursement for immunization administration set by the state Medicaid agency or the contracted Medicaid health plans.
- I will not deny administration of a publicly 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 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).
- I will comply with the requirements for vaccine management including:
  - Ordering vaccine and maintaining appropriate vaccine inventories;
  - Not storing vaccine in dormitory-style units at any time;
  - Storing vaccine under proper storage conditions at all times. Refrigerator and freezer vaccine storage units and temperature monitoring equipment and practices must meet Nebraska Immunization Program storage and handling recommendations and requirements;
  - Returning all spoiled/expired public vaccines to CDC's centralized vaccine distributor within six months of spoilage/expiration

6. To complete the form, please enter the Medical Director's name previously entered on the form and date and then click SAVE:

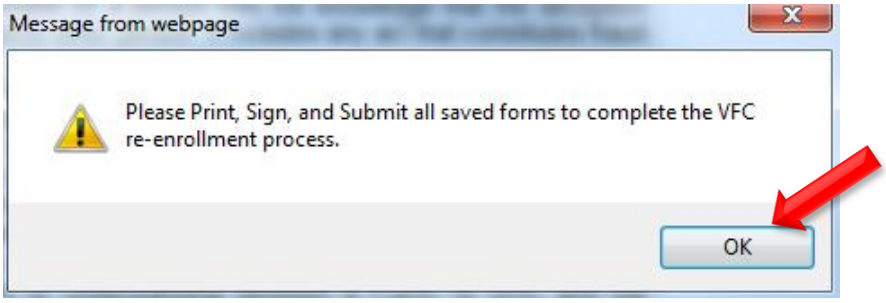
By signing this form, I certify on behalf of myself and all immunization providers in this facility, I have read and agree to the Vaccines for Children enrollment requirements listed above and understand I am accountable (and each listed provider is individually accountable) for compliance with these requirements.

***Medical Director or Equivalent:** Sandra Jackson

***Date:** 01/23/2017

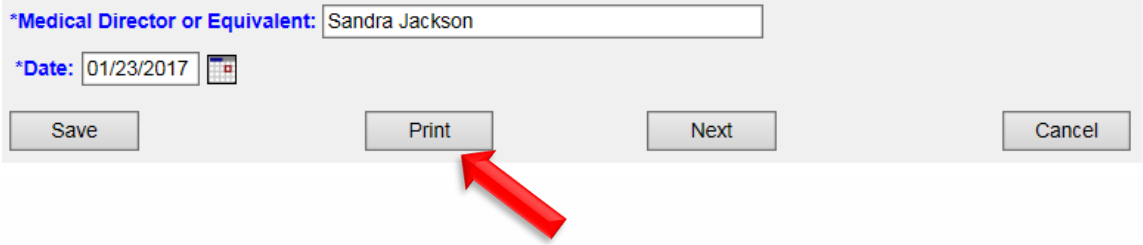
Save Print Cancel

7. Now a pop-up message will appear. Click the OK button:

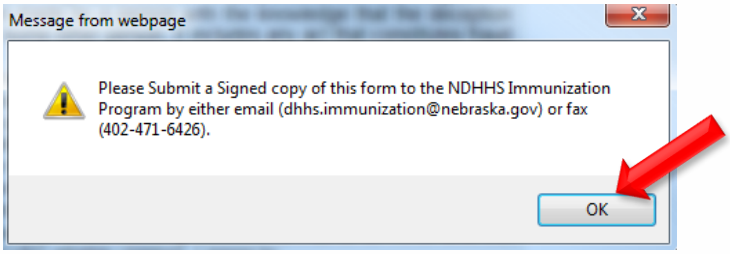


NOTE: If you click "Save" before completing the form, a pop-up box will display, stating "Warning: You have not completed this re-enrollment form. Saving now will not complete the re-enrollment process. You must complete and print all forms before online re-enrollment is completed."

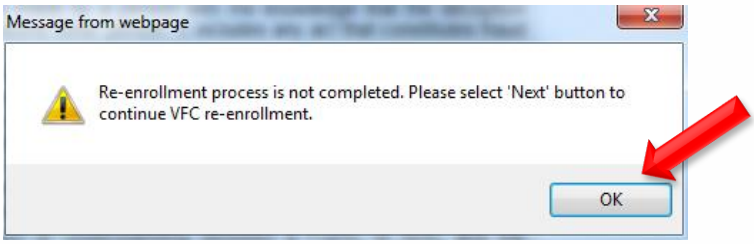
8. Clicking on it will take you to the top of the page, scroll down the page and verify/update the listed information then click PRINT:



9. Selecting PRINT will display a pop-up box with the following message, "Please Submit a Signed copy of this form to the NDHHS Immunization Program by either email dhhs.immunization@nebraska.gov) or fax (402-471-6426)." Select the "OK" button to close the pop-up box:



10. After the first pop-up, a second pop-up message will display, stating "Re-enrollment process is not completed. Please select 'Next' button to continue VFC re-enrollment." Select the "OK" button to close the pop-up box:



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 (and each listed provider is individually accountable) for compliance with these requirements.

*Medical Director or Equivalent: Sandra Jackson

*Date: 01/23/2017

Save | Print | Next | Cancel

VFC Program Provider Profile Form

11. Facility Type – Select the most appropriate type:

home | manage access/account | forms | related links | logout | help desk | training

organization IR Physicians • user Ernad Klipic • role VFC Administrator

VFC Re-Enrollment Forms- Provider Profile

Facility Information

Provider Name: IR Physicians
Provider Identification Number: 33333Z
Facility Name: IR Physicians
Vaccine Delivery Address: 455 Main Address
City: Omaha
State: NE
Zip: 68501 **+4:** 8080
Telephone: 981 080 0808 **Ext.** 8080980808
Email: test@hp.com

Facility Type

12. Vaccines Offered – With the exception of "Specialty Providers," VFC providers must offer all ACIP-recommended vaccines for the populations they serve.

*Vaccines Offered

☐ All ACIP Recommended Vaccines

☐ Offers Select Vaccines (This option is only available for facilities designated as Specialty Providers by the VFC Program)

A "Specialty Provider" is defined as a provider that only serves:

1. A defined population due to the practice specialty (e.g. OB/GYN, STD Clinic, Family Planning)
2. A specific age group within the general population of children ages 0-18

Local health departments and pediatricians are not considered specialty providers. The VFC program has the authority to designate VFC providers as specialty providers. At the discretion of the VFC program, enrolled providers such as pharmacies and mass vaccinators may offer only influenza vaccine.

Select Vaccines Offered by Speciality Provider:

☐ DTaP	☐ Hepatitis A	☐ Hepatitis B
☐ HIB	☐ HPV	☐ Influenza
☐ Meningococcal Conjugate	☐ MMR	☐ Pneumococcal Conjugate
☐ Pneumococcal Polysaccharide	☐ Polio	☐ Rotavirus
☐ Td	☐ Tdap	☐ Varicella
☐ Other, specify:		

13. Provider Population – Annual immunization patient numbers for your facility by age group and VFC eligibility status. Please edit the above tables with accurate numbers reflective of the population you served in the past 12 months. If needed, use the "**Edit**" button to change the values in the tables.

Provider Population

Provider Population based on patients seen during the previous 12 months. Report the number of children who received vaccinations at your facility, by age group. Only count a child once based on their status at the last immunization visit, regardless of the number of visits made. The following tables document how many children received VFC vaccine, by category, and how many received non-VFC vaccine.

VFC Vaccine Eligibility Categories	< 1 Year	1-6 Years	7-18 Years	Total
Enrolled in Medicaid	0	0	0	0
No Health Insurance	0	0	0	0
American Indian/Alaska Native	0	0	0	0
Underinsured in FQHC/RHC or deputized facility*	0	0	0	0
Total VFC	0	0	0	0

Edit

Non-VFC Vaccine Eligibility Categories	< 1 Year	1-6 Years	7-18 Years	Total
Insured (private pay/health insurance covers vaccine)	0	0	0	0
Children's Health Insurance Program (CHIP) **	0	0	0	0
Total Non-VFC	0	0	0	0
Total Patients (must equal sum of Total VFC + Total Non-VFC)	0	0	0	0

Edit

14. Type of Data Used to Determine the Provider Population – Select all that apply, then click SAVE:

***Type of data used to determine provider population (Choose all that apply)**

- ☐ Benchmarking
- ☐ Doses Administered
- ☐ Medicaid Claims Data
- ☐ Provider Encounter Data
- ☐ IIS
- ☐ Billing System
- ☐ Other (must describe):

Save | Print | Cancel

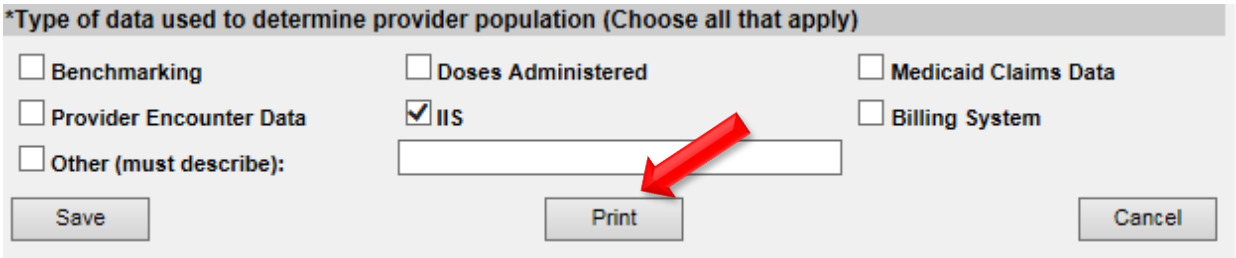
15. Selecting PRINT will display a pop-up box with the following message, "Please Print, Sign, and Submit all saved forms to complete the VFC re-enrollment process". Select the "OK" button to close the pop-up box:

Message from webpage

Please Print, Sign, and Submit all saved forms to complete the VFC re-enrollment process.

OK

16. Clicking on it will take you to the top of the page. Scroll down and verify all the information is all correct, then click PRINT:



17. Clicking on it will take you to the top of the page, scroll down the page and verify/update the listed information then click PRINT:

Please review, print, sign, and fax the forms to the Immunization Program at 402-471-6426 or email it to dhhs.immunization@nebraska.gov.