VACCINES FOR CHILDREN PROGRAM

Washington, D.C., Department of Health, Immunization Program
1131 Spring Road, NW
Washington, DC 20010
Phone (202) 576-7130 Fax (202) 576-6418

PROVIDER AGREEMENT
CITY AND FEDERALLY PURCHASED VACCINE

Date:____

Name of Practice/Clinic:____

Address:____

Telephone: ( )______________________ Fax: ( )__________________________________

Contact person:____

Contact person:____

Medical Director:____

Medicaid Number:_________________________ Medical License Number:__________________

Type of Practice (please check one)

9 Federally Qualified Health Center (FQHC)
9 Public Health Department
9 Public Hospital
9 Private Non-Profit Community Clinic
9 Health Maintenance Organization
9 Other Private:____________________________
9 Public Benefits Corporation
9 Private Practice (individual or group)
9 Private Hospital
9 Community Based Organization
9 Other Public:___________________________

In order to participate in the DC VCF program and/or to receive other federally procured vaccines 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 clinic or other entity of whom I am the physician-in-chief or equivalent, agree to the following:

1. All children (0-18 years) will be screened for VFC eligibility. VFC procured vaccine will only be administered to children who qualify under one or more of the following categories:
   a) Medicaid recipient, b) Alaskan Native or American Indian , c) No health/medical insurance
   d) Health/medical insurance that does not pay for vaccines (only eligible at FQHC)

2. VFC vaccines will be administered only to children in eligible age cohorts for each vaccine as determined by the Advisory Committee on Immunization Practices (ACIP).

3. All patient eligibility screening forms and parent/guardian responses will be maintained in the medical record. Release of such records will be bound by the privacy protection of federal Medicaid law.

4. All immunization records will be made available to the District of Columbia Government or the Department of Health, Immunization Program.

5. The D.C. Immunization Program will be allowed to conduct monitoring visits to provide guidance on vaccine storage, handling and usage, to ensure appropriate eligibility screening and immunization record retention, and to supply educational intervention.

6. The ACIP, AAP and AAFP harmonized immunization schedule, vaccination dosage, and age-appropriate vaccine will be followed.∩ Only true immunization contraindications as determined by the ACIP will be accepted to defer or postpone required immunizations. Exceptions include a) valid medical contraindication, or b) a religious exemption written in good faith, as allowed by the District of Columbia School Immunization Law.

7. The Standards for Pediatric Immunization Practices recommended by the National Vaccine Advisory Committee will be followed.

8. Written vaccine information, such as Vaccine Information Statements (VIS) will be distributed to all clients before the receipt of vaccine and immunization records will be maintained, in accordance with the National Childhood Vaccination Injury Act.∪

9. No charge will be imposed for the cost of any VFC provided vaccine.∪
   a. any imposed administration fee will be no greater than the maximum fee established by the District of Columbia's Medical Assistance Administration (MAA).

10. **VFC immunization services will not be denied** to any child due to inability to pay the administration fee.∪

11. Adverse reactions to vaccine will be reported using the existing system, Vaccine Adverse Events Reporting System (VAERS) to the DOH, Immunization Program in a timely manner.

12. Vaccine inventory, ordering and cold-chain monitoring forms will be submitted as required by the D.C. Immunization Program on a regular basis.

13. Vaccination Administered Record (VAR) will be utilized for all patients receiving VFC and D.C. government procured vaccines. One copy of the VAR form will be submitted to the Immunization Program office to account for vaccine usage. The VAR forms are entered into the Central Immunization Registry (CIR) by DC Immunization Program staff. The information in the CIR may be shared with medical providers, schools, and social services in order to verify vaccination information.

14. Non-VFC federal or city purchased vaccines may be obtained for adult populations under circumstances, such as outbreak control measures or with providers who serve uninsured or low income populations, **only with the permission of the Department of Health, Bureau of Communicable Disease, Immunization Program.** Vaccine may be limited based on availability.

The District of Columbia, Department of Health may terminate this agreement at any time for failure to comply with these requirements. Medical providers may terminate this agreement and return all procured vaccines at any time. Any termination must be in writing.

I understand and agree with the requirements as stated:

____ ____________________________

Authorized Signature/Title Date

This agreement must be submitted and will be kept on file at the DC Department of Health, Immunization Program office and must be updated in accordance with DC VFC policy.

∩ The ACIP immunization schedule and requirements are compatible with the AAP and AAFP recommendations.
∪ Medical providers receiving any vaccine purchased under a federal contract are required to agree to these conditions.

For DC Immunization Program use:

PIN:____________________________ Date Received:_______________ Date Reviewed:_______________

Notes:____

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PROVIDER PROFILE
CITY AND FEDERALLY PURCHASED VACCINE

All District approved public and private health care providers participating in the VFC program and receiving city and federally purchased vaccines must complete this form annually. The information provided helps the District determine the vaccine needs for the VFC program. This form may also be used to compare estimates with actual vaccine supplied to a facility. This record will be kept on file with provider agreement. Please print legibly.

Date:____

Name of Practice/Clinic:____

Address:____

Telephone: ( )________________________ Fax: ( )____________________________________

Contact person:____

Contact person:____

Vaccine Delivery Address:____
(if different)
Vaccine Delivery Days and Times:____

Medical Director:____

Medicaid Number:___________________________ Medical License Number:___________________

Type of Practice (please check one)

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Vaccine usage:
The following information should be based on patient/vaccination data.
For a 12 month period beginning January 1, 2003- December 31, 2003 , please state the number of ALL patients who received immunizations in your facility, by age group.

Age < 1 year	1-6 years	7-18 years	19-26 years	27-59 years	60 and Above	Total

Please document the data source:

9 Benchmarking data
9 Provider encounter data
9 Doses administered data*
9 Medicaid claim forms
9 Vaccine replacement data
9 Other____
9 Registry data
9 Prior vaccine ordering data

* Doses administered data must be converted into the number of children being served.

Vaccine need: Of the children (0-18 years) who will receive VFC vaccines please estimate the number, during the next 12 month period, who will be eligible, by category.

VFC category	Age < 1 year old	1-6 years old	7-18 years old	Total
Enrolled in medicaid				
No health insurance				
American Indian/Alaskan Native				
Underinsured∩				
Total Children				

∩Underinsured children are only eligible to receive VFC vaccine at FQHC.

If you need assistance in determining the patient population who are eligible for VFC vaccine please contact the VFC Program office at (202) 576-7130 ext. 27 or 43.

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Notes:____

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PROVIDER PROFILE- SUPPLEMENTAL
CITY AND FEDERALLY PURCHASED VACCINE

Date:________________ Name of Practice/Clinic:____________________________________

Please list the names of all medical providers in this practice, under whose license that VFC and government procured vaccine may be administered.

Provider name(Last, First, MI)	Title (MD, DO, NP, PA)	Medicaid Provider No.	Medical License No.	Specialty (Peds, FP, GP, etc.)

For DC Immunization Program use:
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