VIRGINIA VACCINES FOR ADULTS PROGRAM PROVIDER AGREEMENT

To be completed by pre-approved adult only FQHCs, CHCs, RHCs, free clinics, safety net clinics, and COVID specialty providers as approved by VDH-DOI.

FACILITY INFORMATION

Facility Name:			Pin#: *(leave blank if not known)*
Facility Address:			
City:	County:	State:	Zip:
Telephone:		Fax:	
Shipping Address (*if different than facility address):*			
City:	County:	State:	Zip:

MEDICAL DIRECTOR OR EQUIVALENT

Instructions: *The official VVFA registered health care 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 VVFA providers with the responsible conditions outlined in the provider enrollment agreement. The individual listed here must sign the provider agreement (page 4).*

Last Name, First, MI:	Title:	Specialty:
License No.:	Medicaid or NPI No.:	Employer Identification No. *(optional):*

Provide Information for second individual as needed: *A second "Medical Director or Equivalent (pg.1)" and second signature line (pg.4) are intended for pharmacists that require a physician to co-sign the Provider Agreement. In jurisdictions where pharmacists are administering vaccines under the direct supervision of a physician, both the pharmacist and the supervising physician must sign the provider agreement.*

Last Name, First, MI:	Title:	Specialty:
License No.:	Medicaid or NPI No.:	Employer Identification No.: *(optional):*

VVFA VACCINE COORDINATOR

Primary Vaccine Coordinator Name:	
Telephone:	Email:
Back-Up Vaccine Coordinator Name:	
Telephone:	Email:

PROVIDERS PRACTICING AT THIS FACILITY *(copy this page if more lines are needed)*

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

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

ROVIDER 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 health care 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 clients 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 and administer publicly purchased and Bridge Access Program vaccines only to adults who are at least 19 years of age. Patients must be at least 19 years of age and meet one of the following categories: o **Uninsured**: Does not have insurance (VVFA eligible) o **Underinsured**: A person who has health insurance, but the coverage does not include vaccines or a person whose insurance does not cover the vaccine being provided; a person whose insurance does not provide first-dollar coverage for vaccines. (VVFA eligible) **Clients with insurance that covers the cost of vaccine, even if the insurance includes a high deductible or co-pay, or if a claim for the cost of the vaccine and its administration would be denied for payment by the insurance carrier because the plan's deductible had not been met are not eligible. As of July 1, 2022, Medicaid covers all routine adult vaccines. Adult patients with full-benefit Medicaid coverage are not eligible to receive VVFA vaccine.**
3.	For the vaccines ordered through VVFA, I will comply with immunization schedules, dosages, and contraindications that are established by the Advisory Committee on Immunization Practices (ACIP) unless: a) In the provider's medical judgment, and in accordance with accepted medical practice, the provider deems such compliance to be medically inappropriate for the client; b) The particular requirements contradict state law, including laws pertaining to religious and other exemptions.
4.	I will maintain all records related to the VVFA program for a minimum of three years and upon request make these records available for review. VVFA records include, but are not limited to, VVFA screening and eligibility documentation or medical record documenting risk factor(s), medical records that verify receipt of vaccine, vaccine ordering records, and vaccine purchase and accountability records.
5.	I will immunize eligible clients with publicly supplied vaccine at no charge to the client for the vaccine.
6.	I will not charge a vaccine administration fee that exceeds the Medicare administration fee cap of $16.96 per vaccine dose. Clients will not be denied vaccine or back-billed if a vaccine administration fee is charged and they are unable to pay. I will accept the reimbursement for immunization administration set by the state agency for Medicare or Medicaid or the related contracted health plans.
7 a. & b.	a. I agree to submit vaccine administration data for all publicly purchased vaccines using Section 317 and state/local funds to the Virginia Immunization Information System (VIIS) in accordance with state regulations and reporting timelines. Data will be entered manually using electronic inventory or sent electronically from our site's electronic medical record. b. I agree to submit vaccine administration data for all Bridge Access Program purchased vaccines to the jurisdiction's Immunization Information System (IIS) in accordance with CDC documentation and data requirements.
8.	I agree to update Vaccines.gov to indicate Bridge Access Program vaccine availability and to make my profile public facing, according to CDC data guidance and timelines
9.	I will distribute the current Vaccine Information Statements (VIS) or Emergency Use Authorization (EUA) fact sheet (if applicable) 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).
10.	I will comply with the requirements for vaccine management as outlined by the Center for Disease Control and Prevention including: a) Ordering vaccine and maintaining appropriate vaccine inventories; b) Not storing vaccine in dormitory-style units at any time; c) Storing vaccine under proper storage conditions at all times. Refrigerator and freezer vaccine storage units and temperature monitoring equipment and practices must meet Virginia Department of Health Immunization Program storage and handling recommendations and requirements; d) Returning all spoiled/expired public vaccines to CDC's centralized vaccine distributor within six months of spoilage/expiration.
11.	I agree to operate within the VVFA 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 VVFA: **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 health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program.
12.	I will participate in VVFA program compliance site visits including unannounced visits, and other educational opportunities associated with VVFA program requirements.
13.	I understand and agree that our site may be liable to replace vaccine on a dose-for-dose basis if the vaccine is deemed non-viable because of provider negligence.
14.	I understand this facility or the Virginia Department of Health Immunization Program may terminate this agreement at any time. Terminations of this agreement by VDH-DOI can be limited to discontinuing the provision of certain vaccines based on availability. If I choose to terminate this agreement, I will properly return any unused VVFA vaccine as directed by the Virginia Department of Health 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 Virginia Vaccines for Adults program 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):

Signature:	Date:

Name (print) *Second individual as needed*: *A second "Medical Director or Equivalent (pg.1)" and second signature line (pg.4) are intended for pharmacists that require a physician to co-sign the Provider Agreement. In jurisdictions where pharmacists are administering vaccines under the direct supervision of a physician, both the pharmacist and the supervising physician must sign the provider agreement.*

Signature:	Date:

Vaccine Shipping Information

	Monday	Tuesday	Wednesday	Thursday	Friday
Business hours for vaccine receipt:	_____	_____	_____	_____	_____

Additional Delivery instructions (ex.: Closed for lunch noon to 1pm) _____

In order for shippers to be able to deliver vaccine, providers must be on site with appropriate staff available to receive the vaccine at least one day per week other than Monday, and for at least four consecutive business hours during that day.

Mailing Information

Mailing Contact _____Office Manager _____

Address_____ City _____State _____Zip Code_____

Type of Facility

☐ Private Practice (COVID Specialty Provider) ☐ Free Clinic ☐ Other Public Facility (i.e. FQHC, RHC, CHC, safety net clinic) _____

Reporting, Vaccine Storage and Handling

Does your site currently use an electronic health records system (EHR)? ___No ___Yes, please specify: _____

Is your site enrolled in the statewide immunization registry (VIIS)? ___No ___Yes, please list Org Code: _____

Does your refrigerator unit maintain proper temperatures? (2°C – 8°C) (36°F - 45°F) __No __Yes
Note – dormitory style refrigerators are not acceptable.
Does your freezer unit maintain proper temperatures? (-15° C) (5° F) or lower __No __Yes
Do you have an ultra-cold freezer (Pfizer's COVID-19 vaccine)? -90ºC and -60ºC (-130ºF and -76ºF) __No __Yes
Do you utilize a continuous temperature monitoring system? __No __Yes

If yes, name of system/brand_____ What is the date of calibration _____

Patient Population: For the 12 month period, estimate the number of clients at your health facility by insurance group and age. Only count a client once regardless of the number of visits made.

Insurance Group	19 – 34 years	35 – 49 years	50+ years
American Indian/Alaska Native[1]			
No Health Insurance			
Underinsured[2]			
Incarcerated			
Medicaid	Not eligible	Not eligible	Not eligible
Medicaid MCO	Not eligible	Not eligible	Not eligible
Insured	Not eligible	Not eligible	Not eligible
Medicare w/Part D or Equivalent	Not eligible	Not eligible	Not eligible

[1] American Indian and Alaska Native patients whose only source of healthcare is provided by an Indian Health Service, Tribal, or Urban Indian healthcare organization are not considered fully insured and may be vaccinated with 317-funded vaccines if the Indian Health Service, Tribal, or Urban Indian healthcare organization does not provide certain vaccines.

[2] A person who has health insurance, but the insurance does not include any vaccines; a person whose insurance covers only selected vaccines; a person whose insurance does not provide first-dollar coverage for vaccines.Note: Eligibility for federally purchased vaccine changes during CDC-declared outbreak response.