VIRGINIA VACCINES FOR ADULTS PROGRAM PROVIDER AGREEMENT

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

FACILITY INFORMATION

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

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 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 for eligibility. Patients must be at least 19 years of age and: 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. (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. 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.	Vaccine provided through VVFA will be accounted for in the Virginia Immunization Information System (VIIS). Data will be entered manually using electronic inventory or sent electronically from our site's electronic medical record.
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 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.
10.	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.

11.	I will participate in VVFA program compliance site visits including unannounced visits, and other educational opportunities associated with VVFA program requirements.
12.	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.
13.	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 VA Zip Code_____

Type of Facility

☐ Free Clinic

☐ Other Facility (i.e. FQHC, RHC, CHC, safety net clinic) _____

Vaccine Storage, Handling, and Reporting

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: _____

Is your refrigerator/freezer unit(s) in good working condition? ☐ Yes ☐ No

Does your refrigerator unit(s) maintain proper temperatures? (2°C – 8°C) (36°F - 45°F)? ☐ Yes ☐ No

Does your freezer unit(s) maintain proper temperatures? (-15° C) (5° F) or lower? ☐ Yes ☐ No

Note – dormitory style refrigerators are not acceptable.

Do you utilize a continuous temperature monitoring system? ☐ No ☐ Yes

If yes, what system/brand do you have? _____

If it is calibrated, what is the date of calibration: _____

Patient Population

Part A. For the 12 month period ending _____/ _____/ _____ (select end date for 12 month estimate)
MM DD Y Y Y Y

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

Insurance Group	# of Patients
Uninsured	
Underinsured	
Medicaid	Not eligible
Medicaid MCO	Not eligible
Insured	Not eligible
Medicare w/Part D or Equivalent	Not eligible
Total	

Note: Eligibility for federally purchased vaccine changes during CDC-declared outbreak response.