Rev October 2008

Provider Site Profile/Enrollment Form
Vaccines for Children Program
Pennsylvania Department of Health

This form must be completed for each site to which vaccines will be shipped. This document provides shipping information and helps the Pennsylvania Department of Health (DOH) determine the amount of vaccine supplied through the VFC program to each provider site. The provider site profile form **must be updated annually** or more frequently if: (1) the number of children served changes; or (2) the type of the facility changes (ie. proper documentation must be forwarded to the DOH before a change in status is made).

Circle one **NEW** **RENEWAL**

PIN Number

PLEASE PRINT OR TYPE

A. Provider/Site Name:______________________________

B. Vaccine Delivery Address (No PO Boxes):______________________________

______________________________ ______________
City State Zip Code County

C. Contact Name: ______________________ Office E-Mail: ______________

Telephone: ( ) ______________________ Fax: ( ) ______________________

D. Type of facility (**Please only check one**): ☐ Federally Qualified Health Center (FQHC); ☐ Rural Health Clinic (RHC); ☐ Pediatrician; ☐ Family Physician; ☐ OB/GYN; ☐ Other ______________________

Annual Patient Population

Years of age	<1	1-6	7-18	≥18**
a. Total Number Enrolled in the Practice (a = b + c + d + e + f)				

DO NOT COUNT A CHILD IN MORE THAN ONE CATEGORY LISTED BELOW.

b. Number of Children Enrolled in Medical Assistance				
c. Number of Uninsured Children				
d. Number of American Indian/Alaskan Native Children				
e. *Number of Underinsured Children (children whose health insurance does not cover vaccines)				
f. Number of Others (those with applicable health insurance, those with health insurance which has a deductible that covers vaccines, and those who do not fall into categories b-e.).				

SPECIAL VACCINE DELIVERY INSTRUCTIONS: ______________________________

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______________________ ______________________ __________
Provider's Name (Print or Type) Provider's Signature Date

Professional License #: ______________________ MA ID # ______________________
(if applicable)

***Underinsured children are only eligible through the PA VFC program if vaccinated at an FQHC or RHC**.
****Persons over 18 years of age are not VFC Eligible**.

<u>The back of this form must be completed</u>, in order for providers to be able to participate in the Vaccines for Children Program. This form will be kept on file at the Pennsylvania Department of Health (DOH). Whenever a provider is added or deleted from the practice, an updated form **MUST BE SUBMITTED** to the DOH.

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PIN Number:

I/WE ARE INTERESTED IN PARTICIPATING IN THE VACCINES FOR CHILDREN PROGRAM AND AGREE TO COMPLY WITH THE POLICIES AND PROCEDURES STATED ON THIS FORM. The following providers will be administering DOH supplied vaccines:

Please list, on the line provided, clinic name and clinic MA ID #: Name______________________________ MA ID# _________________________________

Provider Name (Print or Type)	Provider Signature	Professional License #	MA ID # (if applicable)	Date

Please indicate any changes below:

				☐ Add ☐ Delete
				☐ Add ☐ Delete

Vaccines should be delivered within 30 days of receipt of your order. Vaccines will be shipped to the vaccine delivery address indicated on the provider site profile, which is submitted by the provider prior to ordering vaccine.

I/We will begin using VFC vaccine effective: _________________

In order to participate in the Vaccines for Children (VFC) Program and/or to receive other federally procured vaccine provided to me at no cost, I, on behalf of myself and all practitioners associated with this medical office, group practice, managed care organization, health department, community/rural clinic, or other entity (of which you are physician-in-chief or equivalent) agree to the following:

Please initial each provider enrollment requirement:

_________ I shall screen patients at all immunization encounters for eligibility and administer VFC-purchased vaccine only to children who are 18 years of age or younger who meet one or more of the following categories: a. Are federally vaccine-eligible, that is any or all of the following: (1) Are an American Indian or Alaska Native; (2) Are enrolled in Medicaid; (3) Have no health insurance; (4) Are underinsured (i.e., Children who have commercial (private) health insurance but the coverage does not include vaccines, children whose insurance covers only selected vaccines (VFC-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 vaccine only through a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC).

_________ I shall comply with the recommended immunization schedule, dosage, and contraindications that are established by the Advisory Committee on Immunization Practices (ACIP) and included in the VFC Program unless: 1) In the provider's medical judgment, and in accordance with accepted medical practice, the provider deems such compliance to be medically inappropriate; or 2) The particular requirements contradict state law, including those pertaining to religious and other exemptions.

_________ I shall maintain all records related to the VFC program for 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.

_________ I shall immunize eligible children with VFC-supplied vaccine at no charge to the patient for the vaccine.

_________ I shall not charge a vaccine administration fee to non-Medical Assistance VFC-eligible children that exceeds the administration fee cap of $15.76 per vaccine dose. I shall accept the reimbursement for immunization administration set by the state Medical Assistance agency or the contracted Medical Assistance health plans.

_________ I shall not deny administration of a federally purchased vaccine to an established patient because the child's parent/legal representative of record is unable to pay the administration fee.

_________ I shall distribute the most current Vaccine Information Statements (VIS) each time a vaccine is administered and maintain records in accordance with the National Childhood Vaccine Injury Compensation Act (NCVICA), which includes reporting clinically significant adverse events to the Vaccine Adverse Event Reporting System (VAERS).

_________ I shall comply with the VFC requirements for ordering, vaccine accountability, and vaccine management. I agree to operate within the VFC program in a manner intended to avoid fraud and abuse, including cooperating with all requests made for chart review including allowing review of charts of both VFC eligible and noneligible children.

_________ I or Department of Health (DOH) may terminate this agreement at any time for personal reasons or failure to comply with these requirements. If I terminate the agreement, I agree to properly return any unused VFC vaccine to the DOH, in accordance with instructions provided to me by the DOH.

MAIL COMPLETED FORM TO:

Pennsylvania Department of Health, Division of Immunizations, 625 Forster Street, Room 1026, Harrisburg, PA 17120. Fax: (717) 214-7223 Phone: (717) 787-5681