VACCINES FOR CHILDREN PROGRAM PROVIDER AGREEMENT

FACILITY INFORMATION

Facility Name: COUNTY HEALTH DEPARTMENT			VFC Pin#: NCA000000
Facility Address: 1 MEDICAL CAMPUS DR			
City: ANY TOWN	County: WAKE	State: NC	Zip: 22222
Telephone: 8778736247		Fax: 8005443058	
Shipping Address (*if different than facility address):*			
City:	County:	State:	Zip:

MEDICAL DIRECTOR OR EQUIVALENT

Instructions: *The official VFC registered health care provider signing the agreement must be a practitioner authorized to administer pediatric vaccines under state law who will also be held accountable for compliance by the entire organization and its VFC providers with the responsible conditions outlined in the provider enrollment agreement. The individual listed here must sign the provider agreement.*

Last Name, First, MI: DIRECTOR, MEDICAL	Title: DIRECTOR	Specialty:
License No.:	Medicaid or NPI No.:	Employer Identification No. *(optional):*
Provide Information for second individual as needed:		
Last Name, First, MI: N/A	Title: N/A	Specialty: N/A
License No.: N/A	Medicaid or NPI No.: N/A	Employer Identification No.: *(optional):* N/A

VFC VACCINE COORDINATOR

Primary Vaccine Coordinator Name: PRIMARY COORDINATOR	
Telephone: 8778736247	Email: ncirhelp@dhhs.nc.gov
Completed annual training: ○ Yes ○ No	Type of training received:
Back-Up Vaccine Coordinator Name: BACKUP COORDINATOR	
Telephone: 8778736247	Email: ncirhelp@dhhs.nc.gov
Completed annual training: ○ Yes ○ No	Type of training received:

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 children 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 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: A. Federally Vaccine-eligible Children (VFC eligible) 1. Are an American Indian or Alaska Native; 2. Are enrolled in Medicaid; 3. Have no health insurance; 4. 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. B. State Vaccine-eligible Children 1. 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.
3.	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: 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 child; b) The particular requirements contradict state law, including laws pertaining to religious and other exemptions.
4.	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.
5.	I will immunize eligible children with publicly supplied vaccine at no charge to the patient for the vaccine.
6.	I will not charge a vaccine administration fee to non-Medicaid federal vaccine eligible children that exceeds the administration fee cap of $20.45 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.
7.	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.
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 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 North Carolina Immunization Program storage and handling 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 VFC 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 VFC Program: **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 VFC program compliance site visits including unannounced visits, and other educational opportunities associated with VFC program requirements.
12.	For providers with a signed deputization Memorandum of Understanding between a FQHC or RHC and the North Carolina Immunization Program to serve underinsured VFC-eligible children, I agree to: a) Include "underinsured" as a VFC eligibility category during the screening for VFC eligibility at every visit; b) Vaccinate "walk-in" VFC-eligible underinsured children; and c) Report required usage data Note: *"Walk-in" in this context refers to any underinsured child who presents requesting a vaccine; not just established patients. "Walk-in" does not mean that a provider must serve underinsured patients without an appointment. If a provider's office policy is for all patients to make an appointment to receive immunizations then the policy would apply to underinsured patients as well.*
13.	For pharmacies, urgent care, or school located vaccine clinics, I agree to: a) Vaccinate all "walk-in" VFC-eligible children and b) Will not refuse to vaccinate VFC-eligible children based on a parent's inability to pay the administration fee. Note: *"Walk-in" refers to any VFC eligible child who presents requesting a vaccine; not just established patients. "Walk-in" does not mean that a provider must serve VFC patients without an appointment. If a provider's office policy is for all patients to make an appointment to receive immunizations then the policy would apply to VFC patients as well.*
14.	I agree to replace vaccine purchased with federal funds (VFC, 317) that are deemed non-viable due to provider negligence on a dose-for-dose basis.
15.	I understand this facility or the North Carolina Immunization Program may terminate this agreement at any time. If I choose to terminate this agreement, I will properly return any unused federal vaccine as directed by the North Carolina 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 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 Name (print): MEDICAL DIRECTOR, DIRECTOR	
Signature:	Date:
Name (print) *Second individual as needed*: N/A	
Signature: N/A	Date:

ADDITIONAL PROVIDERS

PROVIDERS PRACTICING AT THIS FACILITY *(attach additional pages as necessary)*

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)*

North Carolina Department of Health and Human Services - North Carolina Immunization Program
2016 LOCAL HEALTH DEPARTMENT VACCINE AGREEMENT

The purpose of this agreement is to authorize COUNTY HEALTH DEPARTMENT (NCA000000) to receive vaccines from the North Carolina Department of Health and Human Services through the Vaccines for Children (VFC) Program. The conditions of the agreement listed below are effective for a period of 12 months.

A. The health director signing this agreement shall:

1. Administer vaccines provided through the North Carolina Immunization Program (NCIP), following all Advisory Committee on Immunization Practices (ACIP) guidelines, charging no third-party for the cost of vaccine. Vaccines received under this agreement must be directly administered to eligible patients and may not be given to non-NCIP health care providers or sold to any other health care provider or to any other person. Incidents of fraud and abuse can result in federal charges and must be reported to the Immunization Branch for investigation per the Fraud and Abuse Policy of the NCIP.
2. Charge no administration fees for uninsured or underinsured patients with family incomes below two hundred percent (200%) of the federal poverty level. Third party billing for administration fees are permitted in accordance with the individual's insurance plan.
3. Impose no inappropriate condition or cost, such as a well-child visit, as a prerequisite to receiving vaccines. Charge no office fee in addition to the administration fee for an immunization–only or walk-in visit.
4. Record the following for each dose of vaccine administered, in the NCIR: (a) the manufacturer, (b) lot number, (c) date of administration, (d) administration site and route, (e) date of the relevant current VIS which was provided, (f) date printed on the VIS, and (g) name, address, and title of the provider who administered the vaccine.
5. Provide a signed immunization record, at no charge, to the parent, guardian, or patient each time an immunization is given as specified in G.S. 130A-154, and when needed for schools, childcare facilities, colleges/universities, or wherever immunization records are required. Keep immunization records, either electronically or in paper form, according to Standard 19 of the NC Record Retention and Disposition Schedules for Counties and Municipalities.
6. Share immunization data upon request as specified in G.S. 130A-153 and 15A NCAC 19A .0406.
7. Assume responsibility for the staff who order, store, administer, and report vaccine usage. Ensure all current and new staff are fully trained in vaccine ordering, storing, handling, administration, use of the NCIR, reporting guidelines, and transportation of vaccine in an emergency situation annually, or more often as needed. Provide documentation (i.e. log sheet) of training participants and dates upon request of NCIP.
8. Assume accountability for all state supplied vaccines received by your health department:
   a. Complete a physical inventory of all state-supplied vaccine at least weekly and properly reconcile with the NCIR at least monthly, with the recommendation of bi-weekly;
   b. Electronically record all vaccines into the NCIR at the time of administration or by the close of business the day the immunization is given;
9. Store vaccine on hand according to the most recent *NCIP Minimum Required Vaccine Ordering, Handling and Storage Procedures*.
10. The health department may be subject to the most current Financial Restitution Policy if vaccines are found to be wasted through the health department's failure to properly store, handle, or rotate the vaccine.
11. Notify the Immunization Branch thirty days prior to a change in the health director who signed this agreement.
12. Notify the Immunization Branch immediately when there are changes to the vaccine coordinator or back-up vaccine coordinator or a change in the health department's shipping and mailing address.

B. With respect to the North Carolina Immunization Registry (NCIR), the health director signing this agreement shall:

1. Designate a minimum of two NCIR Administrators, with active, up-to-date internet email addresses, to ensure that the access level for each user does not exceed that individual's role in the agency and that access is only within the user's scope of work. Deactivate all users immediately should they leave your health department.
2. Require all users accessing NCIR under your authority to sign a *User Confidentiality Agreement*, if they do not currently have one on file at your facility. The agreement must be made available to the Immunization Branch upon request.
3. As much as possible, assure that all patient names entered into the NCIR reflect the patient's true, legally-documented, complete name (e.g., birth certificate).
4. Ensure your facility has a contingency plan in place for use during periods of internal Internet disruption and/or NCIR outages.
5. Acknowledge and agree that the software does not make medical decisions and is not a substitute for competent, properly trained, and knowledgeable staff who bring professional judgment and analysis to the information presented by the software.

The Immunization Branch or health director may terminate this agreement at any time for personal reasons or failure to comply with conditions A.1 through B.5. The health director is required to comply with any additional VFC requirements as the CDC or NCIP may from time to time impose. Upon termination, the health department must properly return all viable, unused NCIP vaccine. All suspensions of eligibility shall be in accordance with G.S. 130A. Individuals and facilities on the "List of Excluded Individuals and Entities" published by the Department of Health and Human Services Office of the Inspector General are prohibited from participating in federally-funded health care programs including the VFC program.

I understand the terms of this agreement and agree to comply with this agreement and the rules promulgated by the State of North Carolina.

_____	MEDICAL DIRECTOR, DIRECTOR	561111111-01	_____
Health Director's Signature (DO NOT USE A STAMP)	Health Director's Name	Tax ID for Local Health Dept.	Date

INSTRUCTIONS

PURPOSE:

This document constitutes a legal agreement under which the North Carolina Immunization Branch may provide vaccines to a local health department to immunize patients and access to the North Carolina Immunization Registry.

PREPARATION:

1. Prepare an original and a copy.
2. Print or type the practice's name.
3. The signature must be of the Local Health Director.
4. The Local Health Director's signature must be an original; a stamp is not acceptable.
5. The agreement shall be available for review by Immunization Branch personnel.

DISTRIBUTION:

1. Mail or fax agreement to:

   Immunization Branch
   1917 Mail Service Center
   Raleigh, North Carolina 27699-1917

   Fax: 1-800-544-3058

2. Retain a copy for your records.

DISPOSITION:

Completed (signed and dated) form must be retained until participation in the state-supplied vaccine program ends and for ten years following the end of the calendar year in which the agreement is terminated or for ten years following the year any vaccine recipient was immunized during the final year of the agreement. If a notice of a claim or lawsuit has been made, this agreement(s) should be retained until after final disposition of the claim or litigation (including appeals).

SUPPORTING DOCUMENTS:

Supporting documents, additional forms, and Branch policies may be obtained at http://www.immunize.nc.gov/ or by calling 1-877-873-6247.

North Carolina Immunization Program
2016 Provider Feedback Survey

We would love to hear what you think about the North Carolina Immunization Program (NCIP). Please take a minute to complete the following survey with respect to our program over the past year. Your answers will help us improve the program to serve both you and our children better. On behalf of the North Carolina Immunization Branch, thank you for your time. NCA000000

Person/Title Completing the Survey (*optional*): _____

PLEASE RATE YOUR EXPERIENCE FOR THE FOLLOWING QUESTIONS USING THE SCALE PROVIDED.

Very Satisfied → Very Dissatisfied

1. The support, information, and materials provided by NCIP program staff. ☺ ○ ○ ○ ☹ NA
2. The helpfulness and professionalism of NCIP Helpdesk staff. ☺ ○ ○ ○ ☹ NA
3. The helpfulness and professionalism of NCIP Regional Nurse and Program Consultants. ☺ ○ ○ ○ ☹ NA
4. The ease of screening patients for Vaccines For Children (VFC) eligibility. ☺ ○ ○ ○ ☹ NA
5. The ease of NCIP record keeping. ☺ ○ ○ ○ ☹ NA
6. The ease of using NCIP vaccine ordering system. ☺ ○ ○ ○ ☹ NA
7. The timeliness of NCIP supplied vaccine delivery. ☺ ○ ○ ○ ☹ NA
8. The condition of NCIP supplied vaccine at delivery.
9. Overall satisfaction with NCIP (if unsatisfied with NCIP, please provide comments). ☺ ○ ○ ○ ☹ NA

_____

_____

_____

10. What recommendations do you have for improving NCIP?

_____

_____

_____

11. Overall satisfaction with the North Carolina Immunization Registry (NCIR). ☺ ○ ○ ○ ☹ NA
12. What recommendations do you have for improving the NCIR?

_____

_____

_____

Any additional comments:

_____

_____

Please fax or mail your completed form to:

Immunization Branch
1917 Mail Service Center
Raleigh, NC 27699-1917

or 1-800-544-3058

2016 North Carolina Immunization Program (NCIP) Provider Profile for:

All health care providers participating in the Vaccines for Children (VFC) program must complete this form annually, or more frequently if the number of children served changes or the status of the facility changes during the calendar year.

DATE COMPLETED: ___ ___ / ___ ___ / 2015

1. FACILITY INFORMATION (verify the information is correct):

Facility Name: Federal Tax ID:

Facility Mailing Address:

City (Mailing) State: Zip Code (Mailing)

2. FACILITY TYPE (select best option):

Private Facilities

- ☐ PRIVATE HOSPITAL
- ☐ PRIVATE PRACTICE (SOLO, GROUP, HMO)
- ☐ PRIVATE PRACTICE (AS AGENT FOR FQHC/RHC-DEPUTIZED)
- ☐ COMMUNITY HEALTH CENTER
- ☐ PHARMACY
- ☐ BIRTHING HOSPITAL
- ☐ SCHOOL-BASED CLINIC
- ☐ TEEN HEALTH CENTER
- ☐ ADOLESCENT ONLY PROVIDER

Public Facilities

- ☑ PUBLIC HEALTH DEPARTMENT CLINIC
- ☐ PUBLIC HEALTH DEPARTMENT (AS AGENT FOR FQHC)
- ☐ PUBLIC HOSPITAL
- ☐ FQHC/RHC (COMMUNITY, MIGRANT, RURAL)
- ☐ COMMUNITY HEALTH CENTER
- ☐ TRIBAL OR INDIAN HEALTH SERVICE
- ☐ WOMEN, INFANTS, AND CHILDREN (WIC)
- ☐ STD/HIV
- ☐ FAMILY PLANNING
- ☐ JUVENILE DETENTION CENTER
- ☐ CORRECTIONAL FACILITY
- ☐ DRUG TREATMENT FACILITY
- ☐ MIGRANT HEALTH FACILITY
- ☐ REFUGEE HEALTH FACILITY
- ☐ SCHOOL-BASED CLINIC
- ☐ TEEN HEALTH CENTER
- ☐ ADOLESCENT ONLY PROVIDER

3. VACCINES OFFERED (select only one box):

☐ All ACIP Recommended Vaccines

☐ Offers Select Vaccines (indicate select vaccines administered, below)

- ○ DTaP
- ○ Hepatitis A
- ○ Hepatitis B
- ○ HIB
- ○ HPV
- ⊘ Influenza
- ○ Meningococcal Conjugate
- ○ MMR
- ○ Pneumococcal Conjugate
- ○ Pneumococcal Polysaccharide
- ○ Polio
- ○ Rotavirus
- ○ TD
- ○ Tdap
- ○ Varicella
- ○ Other, specify:

4. PROVIDER POPULATION (correct any incorrect information):

VFC Vaccine Eligibility Categories	# of Children Who Received VFC Vaccine by Age Category			
	< 1 Year	1 - 6 Years	7 - 18 Years	Total
Enrolled in Medicaid	7	62	150	219
No Health Insurance	2	8	49	59
American Indian/Alaska Native	0	0	0	0
Underinsured* (only applicable for FQHC/RHC or deputized facilities)	0	0	3	3
Total VFC:	9	70	202	281
Non-VFC Vaccine Eligibility Categories	# of Children Who Received Non-VFC Vaccine by Age Category			
	< 1 Year	1 - 6 Years	7 - 18 Years	Total
Insured (private pay/health insurance covers vaccines)	3	11	117	131
North Carolina Health Choice	0	0	16	16
Total Non-VFC:	3	11	133	147
Total Patients (sum of Total VFC + Total Non-VFC)	**12**	**81**	**335**	**428**

* Insurance that does not include vaccines or only covers specific vaccine types.

2016 North Carolina Immunization Program (NCIP) Provider Profile for:

All health care providers participating in the Vaccines for Children (VFC) program must complete this form annually, or more frequently if the number of children served changes or the status of the facility changes during the calendar year.

PROVIDERS PRACTICING AT THIS FACILITY (additional spaces for providers at end of form)				
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)**