Ohio | Department of Health

Mike DeWine, Governor
Jon Husted, Lt.Governor

Stephanie McCloud, Director

Date: February 24, 2021

To: Vaccines for Children (VFC) Providers

From: Kristen Dickerson, PhD, MSN, MPH, RN, MLT (ASCP)
Chief, Bureau of Infectious Diseases

Re: 2021 VFC Provider Enrollment Changes

Due to COVID-19 activities, the Ohio Department of Health (ODH) has extended all submitted 2020 VFC enrollment agreements one additional year through December 31, 2021. Most VFC providers who completed their 2020 VFC enrollment agreement will not need to submit a new 2021 VFC provider profile and enrollment packet.

VFC providers will need to submit a new 2021 VFC enrollment packet only if :

1. Your practice is new to VFC or your practice moved to a new location in 2021.
2. Your VFC Medical Director changed.
3. Your Terminal Distributor of Dangerous Drugs (TDDD) license number changed.

If any of the three criteria listed above are met, complete and submit the two enclosed 2021 VFC enrollment forms:

- Vaccines for Children Program 2021 Provider Profile – Ohio
- Vaccines for Children Program Provider Agreement - 2021

The completed forms should be received by ODH no later than Friday April 30, 2021.
The medical director or equivalent at your enrolled VFC office is required to sign both forms.
After reviewing and completing each form, make a copy for your records and mail the original forms to:

Immunization Program
Bureau of Infectious Diseases
Ohio Department of Health
35 E. Chestnut St., 6th Floor
Columbus, Ohio 43215

If your VFC primary or secondary coordinator changed, please email the ODH VFC program at VFC@odh.ohio.gov and list the new contact name, email address, phone number and VFC practice name.

Thank you for participating in the VFC program and for your efforts to fully immunize Ohio's children and adolescents. If you have any questions, please contact your ODH VFC Consultant at (800) 282-0546 or (614) 466-4643.

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Vaccines for Children Program 2021 Provider Profile – Ohio

Instructions:

1. Complete all sections of page one and page two.
2. Assure the medical director or equivalent signs both forms.
3. Mail the original VFC Program 2021 Provider Profile – Ohio to this address:

Immunization Program
Bureau of Infectious Diseases
Ohio Department of Health
35 E. Chestnut St., 6th Floor
Columbus, Ohio 43215

Provider Demographic Information (*complete all information*)

Facility / Clinic Name:			**VFC #:**
Vaccine Shipping Address:			
City	State	Zip	County
Mailing Address:			
City	State	Zip	County
Telephone Number / Fax Number		Facility Email Address	
Primary VFC Coordinator:	Telephone Number		Email Address
Back-up VFC Coordinator:	Telephone Number		Email Address
Medical Director:	☐ **M.D.** ☐ **D.O.** ☐ **Other:**		
Employer Tax ID #:	**Medical License #:**		
Medicaid Provider #:	**Practice / Clinic NPI:**		

Facility Information (*check each that applies*)

☐ **Private Provider**	☐ **FQHC**	☐ **RHC**	☐ **Adolescent Only**	☐ **Local Health Department**

Facility offers all ACIP recommended vaccines for children 0 – 18 years of age? ☐ **Yes** ☐ **No**

Ohio State Board of Pharmacy Information

The Ohio State Board of Pharmacy requires ODH to ensure that each VFC provider facility is appropriately licensed under Ohio Revised Code (ORC) 4729.51 and pursuant to Ohio Administrative Code (OAC) 4729:6-3-04. The Ohio Department of Health (ODH) must verify that each VFC provider facility has a current Terminal Distributor of Dangerous Drugs (TDDD) license or is exempted from that license according to OAC 4729.541.

Write your facility TDDD license number here ➔

If your practice does not have a TDDD number because of an exemption listed under OAC 4729.541, list the reason for your exemption here:

Facility / Clinic Name:	VFC #:

2021 VFC Patient Eligibility Determination

Determine the number of VFC and non-VFC children at your practice or facility using these criteria:

- Use your practice's electronic medical record (EMR) system or a manual count method with patient charts or lists.
- Count each child **once** if the child received a vaccine during the previous 12-month period.
- Sort the number of counted children by their VFC status and VFC eligibility category.
- Sort the number of counted children by the 3 different age groups listed below.
- **Do not** count the number of doses or shots administered for each child.

Total Number of Children Who Received Vaccines: VFC & NON-VFC Eligible

For the 12-month period ending: _____/ _____ / _____

VFC Vaccine Eligibility Category	Number of children who received VFC vaccine			
	< 1 Year	1 - 6 Years	7 - 18 Years	Total
Enrolled in Medicaid / Medicaid HMO				
No Health Insurance (Uninsured)				
Native American / Alaskan Native				
Underinsured* (only for FQHC, RHC or deputized LHD)				
Total VFC				

***Underinsured children** are eligible to receive VFC vaccines only through a Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC), or deputized local health department. The underinsured include:

- Children who have commercial (private) health insurance, but the coverage does not include any vaccines;
- Children whose insurance covers only selected vaccines (VFC eligible for non-covered vaccines only); and
- Children whose insurance caps vaccine coverage at a certain amount (once that coverage amount is reached, these children are categorized as underinsured). This does not include children with high insurance deductibles.

Non-VFC Vaccine Eligibility Category	Number of children who received non-VFC vaccine			
	< 1 Year	1 - 6 Years	7 - 18 Years	Total
Have Health Insurance (private insurance / non-Medicaid)				
Total Non-VFC				

Type of data used to determine number of VFC and non-VFC children:		
	□ EMR □ Other Immun. Software □ Provider Encounter Data	□ ImpactSIIS Registry □ Billing System □ Medicaid Claims Data

By signing this form, I certify on behalf of myself and all immunization providers at this facility the following:

- **The information contained in the VFC 2021 Provider Profile is accurate.**
- **Each patient will be screened correctly in 2021 for VFC eligibility requirements.**
- **Each patient's VFC status will be documented correctly in 2021.**

Medical Director or Equivalent Name (print):

Signature:	Date:

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VACCINES FOR CHILDREN PROGRAM PROVIDER AGREEMENT - 2021

FACILITY INFORMATION			
Facility Name:			VFC Pin No.:
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 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.*		
Last Name, First, MI:	Title:	Specialty:
License No.:	Medicaid or NPI No.:	Employer Identification No. *(optional):*
Provide information for second individual as needed:		
Last Name, First, MI:	Title:	Specialty:
License No.:	Medicaid or NPI No.:	Employer Identification No. *(optional):*

VFC VACCINE COORDINATOR	
Primary Vaccine Coordinator Name:	
Telephone:	Email:
Completed annual training: ○ Yes ○ No	Type of training received:
Back-Up Vaccine Coordinator Name:	
Telephone:	Email:
Completed annual training: ○ Yes ○ No	Type of training received:

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)*

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 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.	VFC Vaccine Eligible Children I will not charge a vaccine administration fee to non-Medicaid federal vaccine eligible children that exceeds the administration fee cap of $21.25 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. Non-VFC Vaccine Eligible Children I will not charge a vaccine administration fee to non-Medicaid state vaccine eligible children that exceeds the administration fee cap of $21.25 per vaccine dose.
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 Statement (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 Ohio Department of Health 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 with 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 Ohio Department of Health 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 state and 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 Ohio Department of Health 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 Ohio Department of Health.

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):	
Signature:	Date:
Name (print) *Second individual as needed*:	
Signature:	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)***