

VACCINES FOR CHILDREN PROGRAM PROVIDER AGREEMENT

FACILITY INFORMATION			
Facility Name:			VFC Pin#:
Facility Address:			
City:	County:	State:	Zip:
Telephone:		Fax:	
Shipping Address (if different than facility address):			
City:	County:	State:	Zip:
MEDICAL DIRECTOR OR EQUIVALENT			
<p>Instructions: <i>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.</i></p> <p><i>*Note: For the purposes of the VFC program, the term 'vaccine' is defined as any FDA-authorized or licensed, ACIP-recommended product for which ACIP approves a VFC resolution for inclusion in the VFC program.</i></p>			
Last Name, First, MI:			Title:
Specialty:	License No:		Medicaid or NPI No:
Employer Identification Number:			Email:
VFC VACCINE COORDINATOR			
Primary Vaccine Coordinator Name:			
Telephone:		Email:	
Completed annual training: <input type="radio"/> Yes <input type="radio"/> No		Type of training received:	
Back-Up Vaccine Coordinator Name:			
Telephone:		Email:	
Completed annual training: <input type="radio"/> Yes <input type="radio"/> 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 practice administrator 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.	<p>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:</p> <p>A. Federally Vaccine-eligible Children (VFC eligible)</p> <ol style="list-style-type: none"> 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. <p>B. State Vaccine-eligible Children</p> <ol style="list-style-type: none"> a) 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. <p>Children aged 0 through 18 years that do not meet one or more of the federal vaccine eligibility categories (VFC-eligible), are not eligible to receive VFC-purchased vaccine.</p>
3.	<p>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:</p> <ol style="list-style-type: none"> 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.	<p><u>VFC Vaccine Eligible Children</u></p> <p>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.</p> <p><u>Non-VFC Vaccine Eligible Children</u></p> <p>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.</p>
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.	<p>I will distribute the current Vaccine Information Statement (VIS) (or Immunization Information Statement for nirsevimab) each time a vaccine is administered and maintain records in accordance with the National Vaccine Injury Compensation Program (VICP), which includes reporting clinically significant adverse events to the Vaccine Adverse Event Reporting System (VAERS).</p> <p><i>Note: Until a COVID-19 Vaccine Information Statement (VIS) becomes available, provide information prior to vaccination as follows: EUA Fact Sheet for Recipients, Emergency Use Instructions (EUI), or BLA package insert, as applicable.</i></p> <p><i>For nirsevimab when not co-administered with other vaccines, report all suspected adverse reactions to MedWatch. Report suspected adverse reactions following co-administration of nirsevimab with any vaccine to the Vaccine Adverse Event Reporting System (VAERS).</i></p>
9.	<p>I will comply with the requirements for vaccine management including:</p> <ul style="list-style-type: none"> a) Order vaccine and maintain appropriate vaccine inventories; b) Not store vaccine in dormitory-style units at any time; c) Store 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 recommendations and requirements; d) Return all spoiled/expired public vaccines to CDC's centralized vaccine distributor within six months of spoilage/expiration
10.	<p>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:</p> <p>Fraud: 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.</p> <p>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.</p>
11.	I will participate in VFC program compliance site visits, including unannounced visits and other educational opportunities associated with VFC program requirements.

12.	<p>For specialty providers, such as pharmacies, urgent care, school-located vaccine clinics, or birthing hospitals, I agree to:</p> <ul style="list-style-type: none"> 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. <p>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 vaccinations, then the policy would apply to VFC patients as well. “Walk-in” may also include VFC-eligible newborn infants at a birthing facility.</p>
13.	I agree to replace vaccine purchased with state and federal funds (VFC, 317) that are deemed non-viable due to provider negligence on a <u>dose-for-dose</u> basis.
14.	<p>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:</p> <ul style="list-style-type: none"> 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 <p>Submit required deputization reporting data</p> <p>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 vaccinations, then the policy would apply to underinsured patients as well. “Walk-in” may also include VFC-eligible newborn infants at a birthing facility.</p>
15.	<p>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.</p>

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:

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

Vaccines for Children Provider Profile - 2025



Department of
Health

Instructions:

1. Complete all sections of page one and page two.
2. Submit the completed VFC Program 2025 Provider Profile and Provider Agreement in one of the following ways:

a. Email to: vfc@odh.ohio.gov.

b. Fax to 614-728-4279.

c. Mail to: **Immunization Program**
Bureau of Infectious Diseases
Ohio Department of Health
246 N. High St. 2nd Flr
Columbus, Ohio 43215

Provider Demographic Information *(Complete all information)*

Facility / Clinic Name:		VFC #:	Date:
Facility Telephone Number:	Facility Fax Number:	Facility Email Address:	
Vaccine Shipping Address:			
Street Address:			
City:	State:	Zip Code:	County:
Medical Director:		Medical Director: <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> Other:	
Medical Director Email:		Medical License #:	

Provider Type *(Select one)*

- | | | |
|--|---|---|
| <input type="checkbox"/> Private Practice | <input type="checkbox"/> Birthing Hospital | <input type="checkbox"/> Adolescent Only |
| <input type="checkbox"/> Federally Qualified Health Center | <input type="checkbox"/> Local Health Department | <input type="checkbox"/> Urgent Care |
| <input type="checkbox"/> Rural Health Center | <input type="checkbox"/> School-Based Clinic (Permanent location) | <input type="checkbox"/> Private Practice |

If applicable, please indicate the specialty of the provider/practice *(Select all that apply):*

- | | | |
|--|--|-------------------------------------|
| <input type="checkbox"/> Family Medicine | <input type="checkbox"/> Internal Medicine | <input type="checkbox"/> Pediatrics |
| <input type="checkbox"/> Preventive Medicine | <input type="checkbox"/> OB/GYN | <input type="checkbox"/> N/A |

Is this provider site part of a hospital/healthcare system? ☐ Yes ☐ No ☐ N/A or Don't Know

Vaccines Offered *(Select the corresponding option)*

- ☐ Offers all ACIP recommended vaccines for children 0 – 18 years of age?
- ☐ Offers only select vaccines below (only Specialty Providers designated as such by the Immunization Program):
- | | | | |
|----------------------------------|-----------------------------------|---------------------------------|--------------------------------|
| <input type="radio"/> Nirsevimab | <input type="radio"/> Hepatitis B | <input type="radio"/> Influenza | <input type="radio"/> COVID-19 |
|----------------------------------|-----------------------------------|---------------------------------|--------------------------------|

Facility / Clinic Name:		VFC #:		
Ohio State Board of Pharmacy Information				
<p>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.</p>				
Write your facility TDDD license number here:				
If your practice is not required to have a TDDD, list the reason for your exemption here:				
The Ohio State Board of Pharmacy license number for the Ohio Department of Health is: 011987650.				
2025 VFC Patient Eligibility Determination				
<p>Determine the number of VFC and non-VFC children at your practice or facility using these criteria:</p> <ul style="list-style-type: none"> • 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 three 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				
<p>* 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 (LHD). The underinsured include:</p> <ul style="list-style-type: none"> • 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 (privately insurance).				
Total Non-VFC				
Type of Data Used to Determine Number of VFC and Non-VFC Children:	<input type="checkbox"/> EMR <input type="checkbox"/> Other Immun. Software <input type="checkbox"/> Provider Encounter Data			<input type="checkbox"/> ImpactSIIS Registry <input type="checkbox"/> Billing System <input type="checkbox"/> Medicaid Claims Data