

KENTUCKY IMMUNIZATION PROGRAM
VACCINES FOR CHILDREN PROGRAM
2011 PROVIDER ENROLLMENT

Clinic/Practice or Group Name: _____ VFC PIN # _____

County _____ Address _____

City, State and Zip Code: _____

Phone (_____) _____ ext. _____ Fax (_____) _____

E-mail address _____

Employer Identification Number _____
(Federal tax ID #)

Is your clinic a Federally Qualified Health Center (FQHC)? Yes _____ No _____
(If yes, a copy of the certificate must be included with this form.)

Is your clinic a Rural Health Clinic? Yes _____ No _____
(If yes, a copy of the certificate must be included with this form.)

1. Vaccine Shipping Contact Name _____
Last Name First

2. Secondary Vaccine Shipping Contact Name _____
Last Name First

To participate in the Vaccines for Children (VFC) program to receive federally procured vaccine provided to my facility at no cost, I agree to the following conditions on behalf of myself and all practitioners associated with this medical office, group practice, Health Maintenance Organization, community/migrant/rural clinic, health department, or other health delivery facility of which I am the physician-in-chief or equivalent:

1. Screen patients and administer VFC program-purchased vaccine only to a child (≤ 18 years of age) who qualifies under one or more of the following categories: (a) is on Medicaid, or (b) has no health insurance, or (c) is an American Indian or Alaskan Native, or (d) has health insurance that does not pay for the vaccine or are underinsured. Underinsured are children who have private health insurance but the coverage does not include vaccine, 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. (e) A patient that is considered state vaccine-eligible under criteria determined by the Kentucky Immunization Program for vaccine purchased with state funds. Example: universal Hepatitis B birth dose and underinsured patients receiving state supplied vaccines in all provider offices.

2. Comply with the appropriate immunization schedule, dosage, and contraindications that are established by the ACIP and included in the VFC Program unless: (a) in my medical judgment and in accordance with accepted medical practice, I deem such compliance to be medically inappropriate or (b) the particular requirement contradicts the law in my state pertaining to religious or other exemptions. *
3. Maintain all records related to the VFC program for a minimum of 3 years, and make these records available to public health officials, including the Kentucky Cabinet for Health Services or Department of Health and Human Services, (DHHS) upon request. These records include but are not limited to parent/guardian responses on patient eligibility and temperature logs.
4. Immunize eligible children with VFC-supplied vaccine at no charge to the patient for the cost of the vaccine.
5. Not charge a vaccine administration fee to the non-Medicaid VFC eligible child that exceeds the administration fee cap of \$14.17 per vaccine dose. The Centers for Medicare and Medicaid Services Regional Administration Fee Cap from the 2010 VFC Manual is \$14.17 for Kentucky. For Medicaid VFC-eligible children, accept the reimbursement for immunization administration set by the state Medicaid agency or the contracted Medicaid health plans.
6. Not deny administration of a federally purchased vaccine to an established patient because the child's parent/guardian/individual of record is unable to pay the administration fee.
7. 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 Act (NCVIA) which includes reporting clinically significant adverse events to the Vaccine Adverse Event Reporting System (VAERS).
8. Comply with the requirements for ordering, vaccine accountability, and vaccine management. Operate within the VFC program in a manner intended to avoid fraud and abuse.
9. Handle and store vaccine in accordance with vaccine package insert instructions, and may be required to reimburse the Immunization Program dose for dose any state vaccines that I receive for which I cannot account or that spoil or expire because of negligence.
10. Should my staff, representative, or I access VTrckS, I agree to be bound by CDC's terms of use for interacting with the online ordering system. I further agree to be bound by any applicable federal laws, regulations or guidelines related to accessing a CDC system and ordering publically funded vaccines.
11. In advance of any VTrckS access by my staff, representative or myself, I will identify each member of my staff or representative who is authorized to order vaccines on my behalf. In addition, I will maintain a record of each staff member who is authorized to order vaccines on my behalf. If changes occur, I will inform CDC within 24 hours of any change in status of current staff members or representatives who are no longer authorized to order vaccines, or the addition of any new staff authorized to order on my behalf. I certify that my identification is represented correctly on this provider enrollment form.
12. The state or I may terminate this agreement at any time for personal reasons or failure to comply with these requirements. If the provider chooses to terminate the agreement, he or she agrees to notify the program of termination in writing and to properly return all unused VFC vaccine.

Primary Provider or equivalent Signature
(Individual must be authorized to prescribe vaccines in Kentucky)

Date

Please print or type the Primary Provider's Name, Title, Medical License Number, Individual Medicaid Number and the Group Medicaid Number of the primary health providers who may administer vaccine (attach additional copies of the "Additional Providers Within the Practice" form if more space is needed). This first section should be the person who signed the Enrollment on page 2.

Last Name, First, MI

Title (MD, ND, DO, NP, PA) (Provider must have prescription-writing privileges.)

Medical License No.

Medicaid No. (for individual)

Medicaid No. (for the group)

This record is to be submitted to and kept on file at the Kentucky Immunization Program and must be updated in accordance with state policy.

* The ACIP Immunization Schedule is compatible with the AAP & AAFP recommendations.

Additional Providers Within The Practice

Please provide license numbers for all providers at the site that are authorized under state law to prescribe vaccines not only the authorizing provider who signs the enrollment form.

Last Name, First, MI

Title (MD, ND, DO, NP, PA) (Provider must have prescription-writing privileges.)

Medical License No.

Medicaid No. (for individual)

Medicaid No. (for the group)

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2011 DELIVERY HOURS & FREEZER SURVEY

The Varicella (Chickenpox, brand name VARIVAX®) and/or Measles, Mumps, Rubella and Varicella (MMR-V, brand name ProQuad®) vaccines are heat sensitive, live virus vaccines. Because of the temperature restrictions of this vaccine, Merck and Company, Inc. (Manufacturer) will be shipping your VARIVAX® and ProQuad® vaccine orders directly to your office.

Kentucky Vaccines for Children PIN number: _____

Clinic/Practice or Group Name: _____

Please list hours of operation for your office below:

	REGULAR HOURS		OFFICE CLOSED FOR OTHER REASONS (LUNCH, ETC.)	
	OPEN	CLOSE		
MONDAY				
TUESDAY				
WEDNESDAY				
THURSDAY				

I, on behalf of myself and any and all practitioners associated with this medical office, group practice, Health maintenance Organization (HMO), health department, community/migrant/ rural clinic, or other entity of which I am the physician-in-chief, medical director or equivalent, agree to comply with each of Merck & Company’s VARIVAX® and ProQuad® storage requirements listed below.

1. I will protect VARIVAX®/ProQuad® from exposure to light.
2. I will store VARIVAX®/ProQuad® in a freezer that maintains an average temperature of 5°F (-15°C) or colder. Note: Any freezer that reliably maintains the stated temperature and has an external, separate, sealed door, is acceptable for storage of VARIVAX®/ProQuad®.

Acceptable freezers include:

- Household freezers designed to maintain temperatures at or below 5°F (-15°C);
- Frost-free freezers;
- Non-frost-free freezers; or
- Freezer-refrigerator combination units which the freezer is separate, sealed and insulated.

Non-acceptable freezers include:

- Small, “dormitory-type” refrigerators with internal freezers; or
- Freezers that do not meet temperature-maintenance criteria.

3. I will check, twice daily, the temperature in the freezer, in which I have stored VARIVAX®/ ProQuad®.
4. I will not move or transport VARIVAX®/ ProQuad® from the clinic location to which the vaccine is shipped.
5. I will contact the KVP if vaccines become questionable due to exposure to inconsistent temperatures.
6. I will reconstitute VARIVAX®/ ProQuad® only with the diluent supplied with the vaccine and will store the diluent at refrigerator or room temperature. I also will administer VARIVAX®/ ProQuad® within 30 minutes after reconstitution and discard VARIVAX®/ ProQuad® if not used within 30 minutes after reconstitution.

 Primary Provider or equivalent Signature
 (Must be authorized to prescribe vaccines in Kentucky)

 Date

FOR IMMUNIZATION PROGRAM STAFF USE ONLY:

- _____ Approved for freezer vaccines.
 _____ NOT approved for freezer vaccines.

Field Staff Signature: _____ Date: _____

2011 PROVIDER PROFILE

Kentucky Vaccines for Children PIN number: _____

Clinic/Practice or Group Name: _____

	<1 Year	1-6 Years	7-18 Years	Totals
1. For the next 12-month period or one year, calculate the number of children who will receive vaccines supplied by VFC at your practice/clinic:				
2. Of the total number entered in #1 above, how many children are:				
A) Enrolled in Medicaid (Passport included)				
B) Without health insurance or uninsured:				
C) American Indian or Alaska Native				
D) Insurance that does not cover immunizations or underinsured:				
E) KCHIP				
TOTAL (Items A-E): (Total should be the same amount listed in question 1 above.)				

Person completing this form: _____

Date: _____