

## Provider Agreement

### Vaccines for Children Program

---

**In order to participate in the Vaccines for Children (VFC) Program and/or receive other state or federally funded vaccine at no cost, all provider(s) enrolling in the VFC Program (including those associated with the medical office, group practice, health department, community/migrant/rural clinic, or other facility named below), must agree to the following conditions which are further defined in the enclosed Provider Agreement Policy document:**

1. Vaccine supplied by VFC will be administered only to a child  $\leq 18$  years of age who: (a) is enrolled in Medicaid (or qualifies through a Medicaid waiver), (b) has no health insurance, (c) who is an American Indian or Alaska native, (d) has health insurance that does not pay for the vaccine, or (e) is enrolled in the PeachCare for Kids Program.
2. Assess patient eligibility status during the initial visit for each patient receiving vaccines provided by the VFC Program. Subsequent screenings will be conducted to determine whether the child's VFC eligibility status has changed. Eligibility Screening Records will be maintained for a period of three (3) years. If requested, the records will be made available to the Georgia Department of Community Health (DCH) or the United States Department of Health and Human Services (DHHS).
3. Participate in a VFC site visit conducted by an Immunization Program Consultant at least once every two years as measured from the date of the enrollment in the VFC Program of the practice named below.
4. Participate in an assessment of my practice's immunization levels using the Comprehensive Clinical Assessment Software Application (CoCASA) at least once every two years.
5. Comply with the appropriate immunization schedule, dosage, and contraindications that are established by the DHHS Advisory Committee on Immunization Practices (ACIP) unless (a) in making a medical judgment in accordance with accepted medical practice, I deem such compliance to be medically inappropriate or (b) the particular requirement is not in compliance with state law(s) including laws relating to religious or other exemptions.
6. Provide Vaccine Information Statements 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).
7. Not impose a charge for the cost of the vaccine.
8. Not impose a charge to the patient for administration of the vaccine in any amount higher than the current state fee cap of \$14.81 per injection.
9. Not deny administration of a VFC supplied vaccine to a VFC eligible child due to the inability of the child's parent/guardian/individual of record to pay an administration fee. If the parent/guardian/individual of record is unable to pay, the administration fee must be waived. Other visit or office fees may be charged as applicable.
10. Comply with DCH's requirements for ordering vaccine, for reporting vaccine usage, spoilage, expiration and physical inventories, and all other requirements as outlined on the monthly reporting forms.
11. Not be prohibited by Georgia law (i.e., O.C.G.A. Chapters 43-34, 26-4, and 16-13) or any other applicable law from possessing dangerous drugs (i.e., vaccines).
12. Accept the responsibility of maintaining the integrity of the drugs (i.e., vaccines) in accordance with all laws, regulations, and VFC program recommendations pertaining to vaccine storage and handling procedures.
13. Complete and submit to the VFC office the annual Provider Profile Update within 30 days of receipt. Failure to submit this update can lead to deactivation from the VFC program.
14. Comply with all requirements of VFC's Vaccine Tracking System (VTrckS).
  - a) Should the practitioner, staff or representatives of the facility or practitioner named below access VTrckS, each user agrees to be bound by CDC's terms of use for interacting with the online ordering system. Each user further agrees to be bound by any applicable federal laws, regulations, or guidelines related to accessing a CDC system and ordering publically funded vaccines.
  - b) Upon execution of this contract, the name of each member of the facility or practitioner's staff or any person representing the facility or practitioner that will access VTrckS to order vaccines on behalf of the practitioner or facility will be submitted to DCH. In addition, the practitioner or facility will maintain a record of each staff member authorized to order vaccines on behalf of the practitioner or facility. The practitioner or facility will designate a contact person responsible for informing the CDC of changes in the 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 behalf of the practitioner or facility within 24 hours of such change.

15. Pursuant to O.C.G.A. §31-12-3, the vaccination data for every dose of vaccine administered by the clinic will be entered into the Georgia Registry of Immunization Transactions and Services (GRITS) within **10** business days of the service being rendered. See Appendix B, Georgia Immunization Registry Law – O.C.G.A. §31-12-3.1.
16. Understand that this agreement may be terminated by either party at any time for any reason. DCH has the discretion to terminate this agreement for convenience or for the failure of the provider to comply with all requirements.

**Provider Agreement**  
(continued)

Facility Name \_\_\_\_\_

Mailing Address \_\_\_\_\_

Street Address and/or P.O. Box Number

City State Zip Code

If this enrollment is for a hospital, either a hospital pharmacist or administrator must sign this agreement. For other facilities enrolling in VFC, all physicians and mid-level practitioners (nurse practitioners, nurse midwives, and physician assistants) providing service at this location must sign. Also, in order to prevent fraud, abuse, and for other related purposes, a copy of the professional license(s) of the individual(s) listed below and, if applicable, a pharmacy license for the aforementioned facility must be submitted with this enrollment package.

**By signing below, I agree to follow the 16 conditions listed in this Provider Agreement. Failure to abide by any of these conditions may result in termination of enrollment and applicable professional license review.**

Please print or type

Name: (include middle initial and title)	Medicaid Number/License #	Signature
EXAMPLE: Oscar D. Grouch, MD	11122233A/012345	
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Specialty: (Check one only)**

- Pediatrics (Ped)                       General Practice (GP)
- Family Practice (FP)                       Internal Medicine (IM)
- Hospital (Hosp)                       Multiple Specialties (MULT)
- Other, Please Specify: \_\_\_\_\_

Enclosure