



Provider Enrollment
San Antonio Metropolitan Health District
Vaccines for Children Program

Physician or Clinic Name: _____ VFC Code: _____

Address: _____
Street Address _____ City/State/Zip _____
() _____
Telephone _____ Fax _____

Email Address: _____

Contact Name(s): _____

Employer Identification Number: _____
(9 digit tax number assigned by IRS)

Office Manager: _____

Is your practice/clinic a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC)? Yes [] No []

In order to participate in the San Antonio Metropolitan Health District (SAMHD) Vaccine for Children (VFC) Program and/or to receive federally and state supplied vaccines provided to me at no cost, I, on behalf of myself and any and all practitioners associated with this medical office, group practice, health department, community/migrant/rural health clinic, or other organization, agree to the following:

- 1. I will 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 an American Indian or Alaskan Native; b) Is on Medicaid (or qualified through a State Medicaid waiver); c) Has no health insurance; or d) Has health insurance that does not pay for the vaccine (non-VFC vaccine is provided for these children).
2. I will maintain all records to the VFC program for a period of 3 years or longer, and make these records available to the SAMHD, the Texas Department of State Health Services, or the United States Department of Health and Human Services (DHHS).
3. I will comply with the appropriate immunization schedule, dosage, ages and contraindications that are established by the ACIP (and VFC Vaccine Resolutions), 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 the State of Texas pertaining to religious and other exemptions.
4. I will distribute the most current vaccine information statement (VIS) each time a vaccine is administered and will maintain records in accordance with the National Childhood Vaccine Injury Act which includes reporting clinically significant adverse events to the Vaccine Adverse Event Reporting System (VAERS).
5. I will immunize eligible children with VFC-supplied vaccine at no cost to the patient for the vaccine.
6. I will not impose a charge for the administration of the vaccine that is higher than the maximum fee established by the State of \$14.85 per vaccine. For Medicaid VFC-eligible children, 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 federally procured vaccine to a child because the child's parent/guardian/individual is unable to pay the administrative fee.
8. I will comply with the SAMHD's VFC requirements for vaccine ordering, accountability, and management in order to avoid any instances of fraud and abuse. I understand that I will be charged the replacement cost for VFC vaccine that has been lost by my practice due to mismanagement.
9. I agree to participate in VFC educational in-services and site visits at least annually and will permit SAMHD to perform periodic checks of VFC vaccine stored at my facility.
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 SAMHD and 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. I certify/acknowledge that staff employed by this practice are not on the List of Excluded Individuals/Entities (LEIE) that the Office of Inspector General (OIG) maintains which relates to parties excluded from participation in the Medicare, Medicaid and all Federal health care programs.
13. I certify/acknowledge that certified calibrated thermometers must be used in all stand alone or combination refrigeration units with separate doors (no dormitory units) to check temperatures at least twice daily. The certificate accompanying certified thermometers must be retained as proof of certification. I understand that it is the VFC provider's responsibility to keep up with re-certification dates to have thermometers re-calibrated prior to expiration dates to remain compliant with program guidelines.
14. The SAMHD or the provider 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 properly return any unused VFC vaccine.

All licensed Medical Doctors, Doctors of Osteopathy, Nurse Practitioners, Physician Assistants, and Certified Nurse Midwives that are authorized under state law to prescribe vaccines at the clinic location above must sign the VFC Enrollment form.

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| Print Provider Name & Title (MD, PA, etc) | Provider Signature | Date |
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| Medical License Number | Provider Medicaid Number | Specialty (Family Medicine, Pediatrics, etc.) |
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This record is to be submitted to and kept on file at the SAMHD and must be update in accordance with Federal VFC policy.
 *Note: The ACIP Schedule is compatible with the AAP recommendations.