Pennsylvania Department of Health
Vaccines for Children Program Provider Site Profile/Enrollment Form

Both sides of this form must be completed in order for providers to be able to participate in the Vaccines for Children Program; a form must be completed for each site to which vaccines will be shipped. This document provides shipping information and helps determine the amount of vaccine supplied through the VFC program to each provider site. A copy of this form will be kept on file at the Pennsylvania Department of Health (DOH). Questions call 717-787-5681.

The provider site profile/enrollment form must be updated annually or more frequently if:

1) the number of children served changes
2) the type of the facility changes (i.e., proper documentation must be forwarded to the DOH before a change in status is made); or
3) a provider is added or deleted from the practice.

Circle one: NEW ANNUAL RENEWAL UPDATE Pin Number: _____

Site Name: _____ MA ID#: _____

Contact Name: _____

Mailing Address: _____

City: _____ Zip Code: _____ County: _____

Vaccine Delivery Address (No PO Boxes): _____

City: _____ Zip Code: _____ County: _____

Telephone: _____ Fax: _____

Does your medical facility have access to the internet? *(circle one)* Yes No Office Email: _____

Type of facility: *(please only check one)* ☐ Federally Qualified Health Center (FQHC); ☐ Rural Health Clinic (RHC); ☐ Pediatrician; ☐ Family Physician; ☐ OB/GYN; ☐ Other _____

For the 12 month period, report the number of children who received vaccines at your facility, by age group. Only count a child once based on the status at the last immunization visit, regardless of the number of visits made.

Annual Patient Population

All providers, regardless of whether you are currently participating in PA SIIS, must complete the Annual Patient Population portion

Years of age	<1	1-6	7-18	>19**
Total Number Enrolled in the Practice				

DO NOT COUNT A CHILD IN MORE THAN ONE CATEGORY LISTED BELOW.

Number of Children Enrolled in Medical Assistance				
Number of Uninsured Children				
Number of American Indian/Alaskan Native Children				
*Number of Underinsured Children (children whose health insurance does not cover vaccines)				

**Underinsured children are only eligible through the PA VFC program if vaccinated at an FQHC or RHC.*
***Persons 19 and older are not VFC Eligible*

Circle type of data used to determine profile:
A. Benchmarking *C. Dose Administered* *E. Registry*
B. Medical Claims Data *D. Provider Encounter Data* *F. Other*_____

PROVIDER VACCINE DELIVERY HOURS, NOT OFFICE HOURS: INCLUDE LUNCH / TIME STAFF IS NOT AVAILABLE

Monday: _____
Tuesday: _____
Wednesday: _____
Thursday: _____
Friday: _____

The following providers will be administering DOH supplied vaccines:

Provider Name (Print or Type)	Provider Signature	Physician License #	MA ID # (if applicable)	Date

Please indicate any changes to practice staff below:

Add Delete					
Add Delete					

Vaccines will be shipped to the vaccine delivery address indicated on the provider site profile within 30 days of receipt of your order.

I/We will begin using VFC vaccine effective: _____

(Please continue to the next page)

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Pin Number: _____

In order to participate in the Vaccines for Children (VFC) Program and/or to receive other federally procured vaccine provided to me at no cost, I, on behalf of myself and all practitioners associated with this medical office, group practice, managed care organization, health department, community/rural clinic or other entity (of which you are physician-in-chief or equivalent) agree to the following *(please initial each provider enrollment requirement):*

_____ I shall screen patients at all immunization encounters for eligibility and administer VFC-purchased vaccine only to children who are 18 years of age or younger who meet one or more of the following categories: a. Are federally vaccine-eligible, that is any or all of the following: (1) Are an American Indian or Alaska Native; (2) Are enrolled in Medicaid; (3) Have no health insurance; (4) Are underinsured (i.e., Children who have commercial (private) health insurance but the coverage does not include vaccines, 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). Underinsured children are eligible to receive VFC vaccine only through a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC)). b. Are considered state vaccine-eligible under criteria determined by each grantee (e.g., underinsured children not served through an FQHC or RHC, VFC eligible, persons in high-risk groups, persons with no other access to vaccines) for administration of pediatric vaccine purchased with Section 317 or other state funds.

_____ I shall comply with the recommended immunization schedule, dosage and contraindications that are established by the Advisory Committee on Immunization Practices (ACIP) and included in the VFC Program unless: 1) In the provider's medical judgment, and in accordance with accepted medical practice, the provider deems such compliance to be medically inappropriate, or 2) The particular requirements contradict state law, including those pertaining to religious and other exemptions.

_____ I shall maintain all records related to the VFC program for three years and make these records available to public health officials including the state or Department of Health and Human Services (DHHS) upon request. These records shall include, but not be limited to, temperature logs which will include documentation of vaccine temperatures monitored and recorded twice daily, during hours of operation.

_____ I shall not charge a vaccine administration fee to non-Medical Assistance VFC-eligible children that exceeds the administration fee cap of $15.76 per vaccine dose. I shall accept the reimbursement for immunization administration set by the state Medical Assistance agency or the contracted Medical Assistance health plans. I shall immunize eligible children with VFC-supplied vaccine at no charge to the patient for the vaccine.

_____ I shall not deny administration of a federally purchased vaccine to an established patient because the child's parent/legal representative of record is unable to pay the administration fee.

_____ I shall 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 Compensation Act (NCVICA), which includes reporting clinically significant adverse events to the Vaccine Adverse Event Reporting System (VAERS).

_____ I shall comply with the VFC requirements for ordering, vaccine accountability vaccine storage and handling, and vaccine management. I agree to operate within the VFC program in a manner intended to avoid fraud and abuse, including cooperating with all requests made for chart review including allowing review of charts of both VFC eligible and non-eligible children.

_____ I or Department of Health (DoH) may terminate this agreement at any time for personal reasons or failure to comply with these requirements. If I terminate the agreement, I agree to properly return any unused VFC vaccine to the DoH, in accordance with instructions provided to me by the DOH.

I/WE ARE INTERESTED IN PARTICIPATING IN THE VACCINES FOR CHILDREN PROGRAM AND AGREE TO COMPLY WITH THE POLICIES AND PROCEDURES STATED ON THIS FORM.

Provider's Name (Print or Type): _____ Date: _____

Provider's Signature: _____

Physician License #: _____ MA ID #: _____

MAIL COMPLETED FORM TO:

Pennsylvania Department of Health, Division of Immunizations, 625 Forster Street, Room 1026, Harrisburg, PA 17120 Fax: (717) 214-7223