Arizona Vaccines for Adults (VFA) Program
Provider Enrollment Agreement
October 2015 – September 2018

Facility Name:			VFA Pin#:
Facility Address:			
City:	County:	State:	Zip:
Telephone:		Fax:	
Shipping Address (*if different than facility address):*			
City:	County:	State:	Zip:

MEDICAL DIRECTOR OR EQUIVALENT

Instructions: *The official VFA registered health care provider signing the agreement must be a practitioner authorized to administer adult vaccines under state law who will also be held accountable for compliance by the entire organization and its VFA providers with the responsible conditions outlined in the provider enrollment agreement. The individual listed here must sign the provider agreement.*

Last Name, First, MI:	Title:	Specialty:
License No.:	Medicaid or NPI No.:	Employer Identification No. *(optional):*
Provide Information for second individual as needed:		
Last Name, First, MI:	Title:	Specialty:
License No.:	Medicaid or NPI No.:	Employer Identification No.: *(optional):*

Primary Vaccine Coordinator Name:	
Telephone:	Email:
Completed annual training: ☐ Yes ☐ No	Type of training received:
Back-Up Vaccine Coordinator Name:	
Telephone:	Email:
Completed annual training: ☐ Yes ☐ 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 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 adults served changes or 2) the status of the facility changes during the calendar year.
2.	I will screen patients and document eligibility status in the Arizona State Immunization Information System (ASIIS) at each immunization encounter for VFA eligibility and administer VFA vaccine by such category only to adults who are 19 years of age or older who meet one of the following categories: 1. Uninsured: An adult who has no health insurance; 2. Underinsured: An adult who has health insurance, but the coverage does not include vaccines; an adult whose insurance covers only selected vaccines (VFA-eligible for non-covered vaccines only). Adults aged 19 years and older that do not meet at least one of the VFA vaccine eligibility categories are **not** eligible to receive VFA-purchased vaccine.
3.	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 VFA program unless: 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 adult; b) The particular requirements contradict state law, including laws pertaining to religious and other exemptions.
4.	I will maintain all records related to the VFA program for a minimum of six years and upon request make these records available for review. VFA records include, but are not limited to, VFA screening and eligibility documentation, billing records, medical records that verify receipt of vaccine, vaccine ordering records, and vaccine purchase and accountability records. The adult's immunization records must be kept for 10 years as required by state law.
5.	I will immunize eligible adults with publicly supplied vaccine at no charge to the patient for the vaccine.
6.	I will not deny administration of a publicly purchased vaccine to a patient because the adult patient/guardian/individual of record is unable to pay the administration fee.
7.	I will distribute the 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.	I will comply with the requirements for vaccine management including: a) Ordering vaccine and maintaining appropriate vaccine inventories; b) Not storing vaccine in dormitory-style units at any time; c) Storing vaccine under proper storage conditions at all times. Refrigerator and freezer vaccine storage units and temperature monitoring equipment and practices must meet Arizona Immunization Program Office storage and handling requirements; d) Returning all spoiled/expired public vaccines to CDC's centralized vaccine distributor within six months of spoilage/expiration
9.	I agree to operate within the VFA 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 VFA Program: **Fraud:** is an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to the individual or some other person. It includes any act that constitutes fraud under applicable federal or state law.

	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.
10.	I will participate in VFA program compliance site visits including unannounced visits, and other educational opportunities associated with VFA program requirements.
11.	As applies to all providers in state, I agree to report all immunizations administered to adults 19 years of age and older to the Arizona State Immunization Information System (ASIIS) within 30 days of administration. ARS 36-135; ARS 36-374; R9-6-701-707; R9-5-304-305. I will be responsible for the actions of my staff regarding the confidentiality of information contained in the registry system. Staff will adhere to the requirements in the ASIIS Confidentiality Policy, which is incorporated by reference into this agreement. I will submit immunization information to ASIIS via direct data entry or electronic reporting. Paper reporting is no longer an available option.
12.	As applies to all providers in state, I will comply with all rules, statutes, and provisions within the scope of practice issued by the Arizona Medical Board, Arizona Board of Osteopathic Examiners, and the Arizona State Board of Nursing.
12.	I agree to replace vaccine purchased with federal funds that are deemed non-viable due to provider negligence on a dose-for-dose basis.
13.	I understand this facility or the Arizona Immunization Program Office 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 Arizona Immunization Program Office

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 Adults 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:
Name (print) *Second individual as needed*:	
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 *(Optional)***