DEPARTMENT OF HEALTH SERVICES **STATE OF WISCONSIN**
Division of Public Health
F-02495 (05/2019)

VACCINE FOR ADULTS (VFA) PROVIDER AGREEMENT

Please return completed form to: Division of Public Health, Wisconsin Immunization Program, Attn: VFA Program, PO Box 2659 Madison WI 53701-2659.

FACILITY INFORMATION

Facility Name			
Street Address			
City	County	State	Zip code
Telephone No. (Include area code)	Fax No. (Include area code)		
Mailing Address (If different than street address)			
City	County	State	Zip code

MEDICAL DIRECTOR OR AUTHORIZED DESIGNEE INFORMATION

Instructions: Under Wisconsin state law the signee of this provider agreement must be a practitioner authorized to administer vaccines, who will be held accountable for compliance by the entire organization, and its VFA providers to comply with the responsibilities outlined in this provider agreement.

The individual listed below **must** sign the provider agreement.

Medical Director - Name	Title	Specialty
License No.	Medicaid or NPI No.	Employer Identification No. (Optional)
Authorized Designee – Name (If applicable)	Title	Specialty
License No.	Medicaid or NPI No.	Employer Identification No.

VFA VACCINE COORDINATOR INFORMATION

Primary Vaccine Coordinator - Name	Telephone No.	Email
Back-up Vaccine Coordinator - Name	Telephone No.	Email

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 screen patients, and document eligibility status at each immunization encounter for VFA eligibility (i.e., federal or state vaccine-eligible) and administer state supplied-purchased vaccine by such category only to eligible adults in accordance with the Immunization Policy and Procedures.
2.	I will comply with immunization schedules, dosages, and contraindications that are established by the Advisory Committee on Immunization Practices (ACIP) except: 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 recipient; b) The particular requirements contradict state law, including laws pertaining to religious and other exemptions.
3.	I will maintain all records related to the VFA program for a minimum of three 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.
4.	I will not charge a vaccine administration that exceeds the administration fee cap of $20.83 per vaccine dose.
5.	I will not deny administration of a publicly purchased vaccine because the individual is unable to pay the administration fee.
6.	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).
7.	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 Wisconsin Immunization Program storage and handling requirements d) If boxes need to be split, vaccine must be stored in an amber type bag with the bag clearly marked with the vaccine type, lot number, expiration date and the NDC number from the e) Returning all spoiled/expired public vaccines to CDC’s centralized vaccine distributor within six-month of spoilage/expiration

8.	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 **Fraud:** is an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him 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.
9.	I will participate in VFA program compliance site visit, including unannounced visits, and other educational opportunities associated with program requirements.
10.	I agree to replace vaccine purchased with federal funds (317) that are deemed non-viable due to provider negligence on a **dose-for-dose** basis.
11.	I agree to order vaccines through the Wisconsin Immunization Registry, provide doses administered data by dose level to the Wisconsin Immunization Registry, and accept all vaccine transactions via the Wisconsin Immunization Registry. Vaccines should be ordered under “adult”
12.	I understand this facility or the Wisconsin Immunization Program may terminate this agreement at anytime. If I choose to terminate this agreement, I will properly return any unused state provided vaccine as directed by the Wisconsin Immunization Program.
13.	I understand that data loggers are required and will be used in all refrigerators/freezers that contain state-supplied vaccine. Temperatures must be taken and documented once-a-day with minimum and maximum temperatures recorded once a day in the morning.

By signing below, I certify that I am authorized to sign on behalf of myself, all immunization providers in this facility, and this health care facility. I have read and understand the requirements above.

MEDICAL DIRECTOR OR AUTHORIZED DESIGNEE (If applicable)

SIGNATURE – Medical Director	Date Signed
Print Name of Medical Director	

SIGNATURE – Authorized Designee (If applicable)	Date Signed
Print Name of Authorized Designee	

PROVIDER PROFILE

All health care providers participating in the Vaccines for Adults (VFA) program must complete this form annually or more frequently if the number of adults served changes during the calendar year.

Date (mm/dd/yyyy)	**Provider Identification No**

FACILITY INFORMATION

Provider Name

Facility Name

Vaccine Delivery Address

City	State	Zip:

Telephone (Include Area Code)	Email

FACILITY TYPE (select facility type)

☐ **Private Facilities**

- ☐ Private Hospital
- ☐ Private Practice (solo/group/HMO)
- ☐ Private Practice (solo/groups as agent for FQHC/RHC-deputized)
- ☐ Community Health Center
- ☐ Pharmacy
- ☐ Other _____

☐ **Public Facilities**

- ☐ Public Health Department Clinic
- ☐ FQHC/RHC (Community/Migrant/Rural)
- ☐ Community Health Center
- ☐ Tribal/Indian Health Services Clinic
- ☐ Woman Infants and children
- ☐ Other_____
- ☐ STD/HIV
- ☐ Family Planning
- ☐ Correctional Facility
- ☐ Drug Treatment Facility
- ☐ Migrant Health Facility
- ☐ Refugee Health Facility

VACCINES OFFERED (Please check the vaccine(s) that will be administered.)

- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis A/B (Twinrix)
- ☐ HPV
- ☐ Influenza
- ☐ Meningococcal Conjugate
- ☐ MMR
- ☐ Pneumococcal Conjugate
- ☐ Pneumococcal Polysaccharide
- ☐ TD
- ☐ Tdap
- ☐ Varicella
- ☐ Other, specify:_____

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Reset/Clear Entire Form