New Jersey Department of Health
Vaccines for Children (NJVFC) Program
P.O. Box 369
Trenton, NJ 08625-0369
Phone: (609) 826-4862 Fax: (609) 826-4868

VFC NEW PROVIDER ENROLLMENT FOR PEDIATRIC SITE

INSTRUCTIONS: *Email the completed VFC New Provider Enrollment for Pediatric Site and New Provider Agreement for Pediatric Site to: VFC@doh.nj.gov.*

Today's Date *(MM/DD/YYYY)*
__ __ / __ __ / __ __ __ __

PROVIDER INFORMATION

Office Name:

Office Medicaid Number: | Office NPI Number: | Office Tax ID:

Provider Type:

Private Facilities: ☐ Private Practice (solo/group/HMO) ☐ Hospital ☐ Other Private

Public Facilities: ☐ Public Health Department ☐ Hospital ☐ Federally Qualified Health Center ☐ Juvenile Justice Commission ☐ Other Public

Vaccines Offered *(Select only one box)***:**

☐ All ACIP Recommended Vaccines for Children 0 through 18 Years of Age

☐ Offers Select Vaccines ***(This option is only available for facilities designated as "Specialty Providers" by the VFC Program.)***

A "Specialty Provider" is defined as a provider that only serves (1) a defined population due to the practice specialty (e.g., OB/GYN, STD clinic, family planning) or (2) a specific age group within the general population of children ages 0 – 18. Local health departments and pediatricians are not considered specialty providers. The VFC Program has the authority to designate VFC providers as specialty providers.

Select Vaccines Offered by Specialty Provider:

☐ DTaP	☐ Influenza	☐ Polio
☐ Hepatitis A	☐ Meningococcal Conjugate	☐ Rotavirus
☐ Hepatitis B	☐ MMR	☐ TD
☐ HIB	☐ Pneumococcal Conjugate	☐ Tdap
☐ HPV	☐ Pneumococcal Polysaccharide	☐ Varicella

☐ Other *(specify)*:

Vaccine Delivery Address

Address 1: Address 2:

City: State: NJ Zip:

County: Municipality:

Phone: ( ) Ext. Fax: ( )

Email:

LICENSED MEDICAL PROVIDERS *(List all active PA, NP, MD, and DO's at this facility)*

The Medical Director signing this agreement must be authorized to administer pediatric vaccines under state law. The Medical Director will be held accountable for VFC Program compliance by the entire organization with all items stated in the NJVFC Program Provider Agreement.

1. Medical Director Title: ☐ MD ☐ DO Date of Birth:

Last Name: First Name: Middle Name:

NPI No.: Medical License No.: Medicaid No.:

VFC NEW PROVIDER ENROLLMENT FOR PEDIATRIC SITE
(Continued)

LICENSED MEDICAL PROVIDERS, CONTINUED

2. Licensed Medical Provider Title: ☐ MD ☐ DO ☐ PA ☐ NP Date of Birth:

Last Name: First Name: Middle Name:

NPI No.: Medical License No.: Medicaid No.:

3. Licensed Medical Provider Title: ☐ MD ☐ DO ☐ PA ☐ NP Date of Birth:

Last Name: First Name: Middle Name:

NPI No.: Medical License No.: Medicaid No.:

4. Licensed Medical Provider Title: ☐ MD ☐ DO ☐ PA ☐ NP Date of Birth:

Last Name: First Name: Middle Name:

NPI No.: Medical License No.: Medicaid No.:

ASSOCIATED ADDITIONAL MEDICAL OFFICES

(Complete this section only if there are other offices in the practice. If none, go to next section.)

1. Medical Office Name: VFC Pin:

Street 1: Street 2:

City: State: NJ Zip:

County: Municipality:

Phone: ( ) Ext. Fax: ( )

2. Medical Office Name: VFC Pin:

Street 1: Street 2:

City: State: NJ Zip:

County: Municipality:

Phone: ( ) Ext. Fax: ( )

PEDIATRIC SITE CONTACTS

Two designated on-site and fully trained staff responsible for all vaccine management activities within the practice.

Primary Vaccine Coordinator:

Last Name: First Name: Middle Name:

Email: Phone: Ext.

Backup Vaccine Coordinator:

Last Name: First Name: Middle Name:

Email: Phone: Ext.

VFC NEW PROVIDER ENROLLMENT FOR PEDIATRIC SITE
(Continued)

VACCINE DELIVERY HOURS
(Hours when vaccine shipments can be delivered. Exclude lunch hours if office is closed. Note: No deliveries are made on Mondays.)

☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday
From (hh:mm): ____ : ____ To (hh:mm): ____ : ____ AND
From (hh:mm): ____ : ____ To (hh:mm): ____ : ____

☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday
From (hh:mm): ____ : ____ To (hh:mm): ____ : ____ AND
From (hh:mm): ____ : ____ To (hh:mm): ____ : ____

☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday
From (hh:mm): ____ : ____ To (hh:mm): ____ : ____ AND
From (hh:mm): ____ : ____ To (hh:mm): ____ : ____

Special Delivery Instructions: _____

NATIONAL INSTITUTE OF STANDARDS AND TECHNOLOGY (NIST) THERMOMETERS (Enter only one Certification Number for dual probe thermometer Certificates. Digital min/max thermometers with glycol filled probes are not fluid filled thermometers.)

Thermometers:

1. Type:	☐ Data Logger ☐ Digital Min/Max Thermometer	Certification or Serial Number:		NIST Certification Expiration Date:	
2. Type:	☐ Data Logger ☐ Digital Min/Max Thermometer	Certification or Serial Number:		NIST Certification Expiration Date:	
3. Type:	☐ Data Logger ☐ Digital Min/Max Thermometer	Certification or Serial Number:		NIST Certification Expiration Date:	
4. Type:	☐ Data Logger ☐ Digital Min/Max Thermometer	Certification or Serial Number:		NIST Certification Expiration Date:	

Back-Up Thermometer *(Required)*:

1. Type:	☐ Data Logger ☐ Digital Min/Max Thermometer	Certification or Serial Number:		NIST Certification Expiration Date:	

VFC NEW PROVIDER ENROLLMENT FOR PEDIATRIC SITE
(Continued)

PROVIDER POPULATION

Provider Population based on patients seen during the previous 12 months. Report the number of children who received vaccinations at your facility, by age group. Only count a child once based on the status of the last immunization visit, regardless of the number of visits made. The following table documents how many children received VFC vaccine, by category, and how many received non-VFC vaccine.

	Number of Children who Received Vaccine by Age Category		
VFC Vaccine Eligibility Categories	**Under 1 Year**	**1-6 Years**	**7-18 Years**
• Enrolled in Medicaid or NJ FamilyCare Plan A			
• No Health Insurance			
• American Indian/Alaska Native			
• Underinsured (In FQHC) [1]			
Non-VFC Vaccine Eligibility Categories	**Under 1 Year**	**1-6 Years**	**7-18 Years**
• Insured (private pay/health insurance covers vaccines)			
• Children's Health Insurance Program (NJ FamilyCare B, C, D) [2]			

[1] *Underinsured includes children with health insurance that does not include vaccines or only covers specific vaccine types. Children are only eligible for vaccines that are not covered by insurance. In addition, to receive VFC vaccine, underinsured children must be vaccinated through a Federally Qualified Health Center (FQHC).*

[2] *These children are considered insured and are not eligible for vaccines through the VFC Program.*

TYPE OF DATA USED TO DETERMINE PROVIDER POPULATION *(Choose ALL that apply):*

☐ Benchmarking ☐ NJIIS ☐ Provider Encounter Data

☐ Medicaid Claims Data ☐ Doses Administered ☐ Billing System

☐ Other *(must describe)*:

The Medical Director signing this agreement must be authorized to administer pediatric vaccines under state law. The Medical Director will be held accountable for VFC Program compliance by the entire organization with all items stated in the NJVFC Program Provider Agreement.

Print Name of Medical Director | Signature of Medical Director: | Date:

FOR STATE USE ONLY							
Date Certified for NJVFC		Staff Name		PIN Number			
Federal HHS OIG Search Done	☐ Yes ☐ No	NJ Consumer Affairs OIG Search Done	☐ Yes ☐ No	Address Checked on USPS Site	☐ Yes ☐ No	Correction made to conform to USPS Address	☐ Yes ☐ No
Document clarification of HHS OIG an NJ Division of Consumer Affairs issues here:							

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NEW PROVIDER AGREEMENT FOR PEDIATRIC SITES

***Instructions**: Email the completed VFC New Provider Agreement for Pediatric Sites and the New Provider Enrollment for Pediatric Sites to: VFC@doh.nj.gov.*

Office Name	Office Medicaid Number

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 healthcare 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 children served changes or (2) the status of the facility changes during the calendar year.
2. I will screen patients and document eligibility status at each immunization encounter for VFC eligibility (i.e., federally or state vaccine-eligible) and administer VFC-purchased vaccine by such category only to children who are 18 years of age or younger who meet one or more of the following categories:
   A. Federally vaccine-eligible children (VFC eligible):
      (1) are an American Indian or Alaska Native;
      (2) are enrolled in Medicaid;
      (3) have no health insurance;
      (4) are underinsured: A child who has health insurance, but the coverage does not include vaccines; a child whose insurance covers only selected vaccines (VFC-eligible for non-covered vaccines only). Underinsured children are eligible to receive VFC vaccine only through a Federally Qualified Health Center (FQHC), or Rural Health Clinic (RHC) or under an approved deputization agreement.
   B. State vaccine-eligible children:
      (1) In addition, to the extent that my state designates additional categories of children as "state vaccine-eligible," I will screen for such eligibility as listed in the addendum to this agreement and will administer state-funded doses (including 317 funded doses) to such children.

   Children aged 0 through 18 years that do not meet one or more of the eligibility federal vaccine categories (VFC eligible) are NOT eligible to receive VFC-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 VFC Program unless:
   A. In the provider's medical judgement, and in accordance with accepted medical practice, the provider deems such compliance to be medically inappropriate for the child.
   B. The particular requirements contradict state law, including laws pertaining to religious or other exemptions.
4. I will maintain all records related to the VFC Program for a minimum of three years and, upon request, make these records available for review. VFC records include, but are not limited to, VFC screening and eligibility documentation, billing records, medical records that verify receipt of vaccine, vaccine ordering records, and vaccine purchase and accountability records.
5. I will immunize eligible children with publicly supplied vaccine at no charge to the patient for the vaccine.
6. I will not charge a vaccine administration fee to non-Medicaid federal vaccine-eligible children that exceeds the administration fee cap of $24.23 per vaccine dose. For Medicaid children, I will 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 publicly-purchased vaccine to an established patient because the child's parent/guardian/individual or record is unable to pay the administration fee.
8. 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).
9. 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 the New Jersey Vaccines for Children Program (NJVFC) storage and handling requirements.
   D. Returning all spoiled/expired public vaccines to CDC's centralized vaccine distributor within six months of spoilage/expiration.
10. I agree to operate within the VFC 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 VFC 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 himself 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.
11. I will participate in VFC program compliance site visits including unannounced visits, and other educational opportunities associated with VFC program requirements.
12. I agree to replace vaccine purchased with federal funds (VFC, 317) that are deemed non-viable due to provider negligence on a dose-for-dose basis.
13. Per N.J.A.C. 8:57-3.16, I understand that all providers administering vaccines to children less than 7 years of age must register as a provider with the New Jersey Immunization Information System (NJIIS) and report vaccinations online within 30 days. Additionally, I understand that the NJ VFC program requires every VFC provider to enter all vaccinations given with VFC-supplied vaccine, including 317-funded vaccine, into NJIIS within 30 days of administration (regardless of the age of the patient) and agree to comply with this mandate.
14. I understand this facility or the New Jersey Vaccines for Children Program 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 New Jersey Vaccines for Children Program.

By signing below, I acknowledge that I have read and accept the Provider Enrollment Agreement.

Print Name of Medical Director:		Signature of Medical Director:		Date:	