

## PROVIDER CERTIFICATION NM VACCINES FOR CHILDREN PROGRAM

VFC PIN #: \_\_\_\_\_

Chief Provider's Name: \_\_\_\_\_  
First MI Last

Facility Name: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip Code

Telephone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_ **Email(required):** \_\_\_\_\_

a. Contact Name: \_\_\_\_\_  
First Last

b. Contact Name: \_\_\_\_\_  
First Last

To participate in the NM Vaccines for Children (VFC) program and receive vaccines provided to my facility at no cost, I agree to the following conditions on behalf of myself and all staff associated with this medical office, group practice, Health Maintenance Organization, community/migrant/rural clinic, health department, or other health delivery facility of which I am the physician-in-chief or equivalent:

1. Screen children at all immunization encounters for eligibility and administer VFC vaccine **only to children who are 18 years of age or younger**. NM is a universal state, so all children, with or without insurance are eligible to receive vaccines provided by the NM VFC Program as long as they are 18 years of age or younger.

However, providers are required to determine each child's VFC category status at each vaccine visit by determining if the child (18 years of age or younger) is:

- a) enrolled in Medicaid/Salud
- b) uninsured
- c) American Indian
- d) underinsured
- e) insured

**Children in all categories a – e above are eligible to receive NM VFC vaccines as long as they are 0 through 18 years of age.** The Vaccines for Children program does **not** provide vaccines for anyone over 18 years of age.

2. Comply with immunization schedules, dosages, and contraindications as established by the Advisory Committee on Immunization Practices (ACIP) and included in the VFC 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;
- b) the particular requirements contradict state law, including laws pertaining to religious and other exemptions.

3. Maintain all records related to the VFC program for a minimum of 3 years, and make these records available to public health officials, including the NM Department of Health or the U.S. Department of Health and Human Services upon request.

4. Immunize eligible children with VFC-supplied vaccines at no charge for the vaccines.

5. Not charge a vaccine administration fee to non-Medicaid VFC-eligible (uninsured) children that exceeds the NM vaccine administration fee cap of \$14.28 per vaccine dose. For Medicaid VFC-eligible children, accept the reimbursement for vaccine administration set by the state Medicaid agency or contracted Medicaid health plans, or for insured children, accept the vaccine administration reimbursement allowable by the insurer.
6. Not deny administration of VFC vaccines to any child because the child's parent/guardian/individual of record is unable to pay the vaccine administration fee. Other visit or office fees may be charged as applicable.
7. Provide current Vaccine Information Statements (VISs) each time a vaccine is administered and maintain records in accordance with the National Childhood Vaccine Injury Compensation Act, which includes reporting clinically significant adverse events to the Vaccine Adverse Event Reporting System (VAERS).
8. a) Comply with requirements for vaccine ordering, vaccine accountability, and vaccine management. Agree to operate within the VFC program in a manner intended to avoid fraud and abuse.  
b) Comply with vaccine management practices addressed in the *Vaccine Storage & Handling Guide*. Submit temperature logs by the 1<sup>st</sup> of every month to the regional VFC coordinator for refrigerators and freezers, recording temperatures twice daily in Fahrenheit on temperature logs provided by VFC. Adhere to NM VFC *Vaccine Storage & Handling Guide* protocols, including protocols addressing out of range temperatures.  
c) Use certified, NIST calibrated thermometers provided by VFC in all refrigerators and freezers.  
d) Ensure that a Vaccine Disaster Recovery Plan (emergency plan) is posted and that all staff are familiar with the plan.  
e) Notify VFC immediately of changes in provider address, vaccine shipping contact staff or the chief physician/primary provider.  
f) Participate in CASA/AFIX clinic assessments as requested and participate in at least one VFC training session per year.  
g) Comply with requirements **for direct data entry** of Part B form data into the NM Statewide Immunization Information System (NMSIIS). Data must be entered into NMSIIS within one week of vaccine administration.  
h) Maintain VFC vaccine inventory in NMSIIS.  
i) Provide VFC with current email address(es) and update as needed by contacting [Lynne.Padilla-Truji@state.nm.us](mailto:Lynne.Padilla-Truji@state.nm.us)
9. Accept financial responsibility for the replacement cost of VFC vaccines that are received but either unaccounted for, expired or wasted due to provider/staff negligence. Upon determination by the NM Department of Health that the cost of unused vaccines due to waste or expiration is in excess of 5% of the total cost of vaccines received in the past year, the NM Department of Health may terminate this agreement.
10. The NM Department of Health 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, s/he agrees to properly return any unused VFC vaccines.

\_\_\_\_\_  
Chief Physician/Primary Provider's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Chief Physician/Primary Provider's Name - Printed

## Provider List

Please print the names and medical license numbers of all health providers (**MD, DO, NP, PA only**) who may administer vaccines.

_____	_____	_____	_____	_____	_____
Last Name,	First,	MI	Medical License No.	Title (MD,DO,NP,PA) (Provider must have prescription writing privileges)	Specialty (Peds, Family Med, GP, Other (specify))
_____	_____	_____	_____	_____	_____
Last Name,	First,	MI	Medical License No.	Title(MD,DO,NP,PA) (Provider must have prescription writing privileges)	Specialty (Peds, Family Med, GP, Other (specify))
_____	_____	_____	_____	_____	_____
Last Name,	First,	MI	Medical License No.	Title(MD,DO,NP,PA) (Provider must have prescription writing privileges)	Specialty (Peds, Family Med, GP, Other (specify))
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Last Name,	First,	MI	Medical License No.	Title(MD,DO,NP,PA) (Provider must have prescription writing privileges)	Specialty (Peds, Family Med, GP, Other (specify))
_____	_____	_____	_____	_____	_____
Last Name,	First,	MI	Medical License No.	Title(MD,DO,NP,PA) (Provider must have prescription writing privileges)	Specialty (Peds, Family Med, GP, Other (specify))
_____	_____	_____	_____	_____	_____







## Weekly Immunization Population Benchmark Chart

VFC Pin# : \_\_\_\_\_

Facility Name: \_\_\_\_\_

Page \_\_\_\_\_ of \_\_\_\_\_

Completed By: \_\_\_\_\_ Phone Number : \_\_\_\_\_

Dates covered in this benchmark chart (one month) \_\_\_\_\_ to \_\_\_\_\_

Week of \_\_\_\_\_ (month) \_\_\_\_\_ (day) \_\_\_\_\_ (year)

	< 1 Year Old	1-6 Year Olds	7-18 Year Olds
Medicaid/Salud			
No Health Insurance			
American Indian			
Has Private Insurance			
<b>Total Children Who Received Immunizations</b>	(Add Column)	(Add Column)	(Add Column)

*Complete EITHER the Provider Profile OR the Benchmark.*

1. Complete one form for each week in a one-month period. Note the week's date on each sheet.
2. Place the form on the refrigerator, at the front desk or another appropriate location. Instruct all staff who give shots to identify ages of patients and how to complete the form.
3. When a patient who is 0 through 18 years of age receives a shot, enter a mark in the appropriate block by age and insurance status.
4. Do not double count children. This is a record of child visits per week. NOT the number of injections given.
5. Count each child in one category only. If a child is American Indian, ONLY count that child in the American Indian Category. Do NOT count American Indian children in any other category.
6. Every child who is 0 through 18 years of age and who is immunized during the month-long time period should be entered according to age and insurance status. REMEMBER that in NM, all children who meet the age criteria of 0 through age 18, with or without insurance, can receive VFC vaccines.

## FREEZER CERTIFICATION

*Your freezer must be approved before you can order Varicella and/or MMRV vaccines.*

DATE: \_\_\_\_\_

FACILITY NAME: \_\_\_\_\_

VFC PIN#: \_\_\_\_\_

CONTACT PERSON: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_

E-MAIL ADDRESS: \_\_\_\_\_

1. I'M INTERESTED IN STOCKING VARICELLA/MMRV VACCINES AT MY FACILITY.

YES \_\_\_\_\_ NO \_\_\_\_\_

2. SIZE OF YOUR REFRIGERATOR /FREEZER

\_\_\_\_\_ A) Full-size refrigerator/freezer (freezer maintains temperatures at 5°F or colder)

\_\_\_\_\_ B) 3-4 foot refrigerator with sealed freezer compartment and exterior freezer door  
(Freezer maintains temperatures at 5°F or colder)

\_\_\_\_\_ C) Commercial: \_\_\_\_\_

If you have any other type of freezer than those listed above; please indicate: \_\_\_\_\_

3. YEAR OF PURCHASE: \_\_\_\_\_

4. DO YOU HAVE A THERMOMETER IN YOUR FREEZER? YES \_\_\_\_\_ NO \_\_\_\_\_

5. DO YOU HAVE A THERMOMETER IN YOUR REFRIGERATOR? YES \_\_\_\_\_ NO \_\_\_\_\_

6. WHAT ARE YOUR REGULAR OFFICE HOURS? \_\_\_\_\_

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VFC APPROVES THE ABOVE FACILITY FOR VARICELLA VACCINE:

YES \_\_\_\_\_ NO \_\_\_\_\_ DATE: \_\_\_\_\_ INITIALS: \_\_\_\_\_