

IMPORTANT!

To: NM Vaccines for Children (VFC) Providers
From: Carly Christian, VFC Manager
Date: May 18, 2011
Re: 2011 VFC Certification

Thank you for your continuing participation in the NM Vaccines for Children (VFC) Program. It's time again for the annual VFC certification required by the Centers for Disease Control. All VFC providers are required to submit annual VFC certification forms in order to continue receiving VFC vaccines.

Please complete items # 1 - 4 below and return no later than June 3rd.

Your VFC vaccine orders will not be filled if we have not received ALL of these by June 3rd:

- 1) Provider Certification (3 pages)
- 2) Provider List
- 3) Provider Profile (2 pages)
- 4) **Required:** Copy of your current NM State Board of Pharmacy Clinic License
OR Copy of NM Board of Medical Examiners License (if chief provider is MD)
OR Copy of NM Board of Osteopathic Medical Examiners License (if chief provider is DO)
OR Copy of NM Board of Nursing-Nurse Practitioner License (only if chief provider is NP)

Return by June 3rd to:

Lynne Padilla-Trujillo
VFC Program-Immunizations
NM Department of Health
1190 St. Francis Dr., S-1264
Santa Fe, NM 87502
FAX 505-827-1741 or 505-827-1064

If you have questions, please contact Lynne Padilla-Trujillo at 505-827-2147

Lynne.Padilla-Truji@state.nm.us

PROVIDER CERTIFICATION NM VACCINES FOR CHILDREN PROGRAM

VFC PIN #: _____

Chief Provider's Name: _____
First MI Last

Facility Name: _____

Mailing Address: _____
Street City State Zip Code

Telephone: () _____ Fax: () _____

a. Contact Name: _____ Email (required): _____
First Last

b. Contact Name: _____ Email (required): _____
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 patients at each immunization encounter for VFC eligibility and administer VFC-purchased vaccines **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 that are 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.

All VFC-enrolled primary care providers are expected to offer all ACIP-recommended vaccines.

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 Department of Health and Human Services (DHHS) upon request.

4. Immunize eligible children with VFC-supplied vaccines at no charge to the patient, Medicaid/Salud or the insurer for the vaccines.

VFC PIN #: _____

5. Not charge a vaccine administration fee to non-Medicaid VFC-eligible patients (uninsured, American Indian, underinsured) that exceeds the NM vaccine administration fee cap of \$14.28 per vaccine dose. For Medicaid/Salud VFC-eligible children, accept the reimbursement for vaccine administration set by the state Medicaid agency or contracted Medicaid health plans. For insured children, accept the vaccine administration reimbursement allowed by the insurer.
6. Not deny administration of VFC vaccines to an established patient because the child's parent/guardian/individual of record is unable to pay the vaccine administration fee. The only fee that must be waived is the vaccine administration fee.
7. Distribute the most 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 1st 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 storage and handling emergency plan is posted on each refrigerator 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. Immediately submit a VFC Change of Information form if vaccine personnel or shipping address change.
 - 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 entry** of Part B form data by the provider into the NM Statewide Immunization Information System (NMSIIS) or initiate electronic data exchange between NMSIIS and the electronic health record (EHR) system of the provider. Data must be entered into NMSIIS within three weeks of vaccine administration, and preferably within one week.
 - h) Maintain VFC vaccine inventory in NMSIIS.
 - i) Provide VFC with current email addresses and update as needed by contacting Lynne.Padilla-Truji@state.nm.us
9. Agree to be bound by CDC's terms of use for interacting with the online ordering system should my staff, representative, or I access VTrckS. I further agree to be bound by any applicable federal laws, regulations or guidelines related to accessing a CDC system and ordering publicly funded vaccines.
10. Identify each member of my staff or representative who is authorized to order vaccines on my behalf in advance of any VTrckS access by my staff, representative or myself. In addition, I will maintain a record of each staff member who is authorized to order vaccines on my behalf. After VTrckS implementation, if changes occur, I will inform CDC within 24 hours of any change in status of current staff members or representatives who are no longer authorized to order vaccines, or the addition of any new staff authorized to order on my behalf. I certify that my identification is represented correctly on this provider enrollment form.

VFC PIN #: _____

11. 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.

12. 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 professional license numbers of all providers (**MD, DO, NP, PA only**) in the practice who are authorized to prescribe vaccines under state law.

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))
			Medicaid Provider No.		

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Provider Profile (continued) NM Vaccines for Children Program

Provider Estimates:

Part A. For the 12 mo. period ending / /
MM DD YY

VFC Pin #: _____

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

< 1 year old	1-6 Years	7-18 Years	Total
a)	b)	c)	d)

Part B. Of the total number for each age group entered above (a, b, c, d), how many children were in each category below? **Note: Indicate numbers of children, NOT percentages or visits**

	< 1 year old	1-6 Years	7-18 Years	Total
Enrolled in Medicaid/Salud				
No Health Insurance				
American Indian*				
Underinsured*				
Have Health Insurance				
Totals (Note: Totals must match totals in Part A, a – d)	a)	b)	c)	d)

*If American Indian, count child in American Indian category only.

*Underinsured: a child who has commercial health insurance but the coverage does not include vaccines, a child whose insurance covers only selected vaccines, or a child whose insurance caps vaccine coverage at a certain amount. Once that coverage amount is reached, the child is categorized as underinsured.

Type of data used to determine profile:

- | | |
|--|--|
| <input type="checkbox"/> A. Benchmarking
<input type="checkbox"/> C. Doses Administered
<input type="checkbox"/> E. NMSIIS | <input type="checkbox"/> B. Medicaid/Salud Claims Data
<input type="checkbox"/> D. Provider Encounter Data
<input type="checkbox"/> F. Other _____ (specify) |
|--|--|