

Provider Agreement

Connecticut Vaccines For Children Program

I certify that in administering the vaccine I/we receive from the Connecticut Vaccines for Children (VFC) program for use in this facility will agree to the following:

1. I/We agree to provide the Connecticut Immunization Program with the numbers of children 0-18 years of age expected to be seen at this facility/practice for the 12 month period beginning on October 1, 2003 who will meet one or more of the following criteria: (A) enrolled in the Medicaid Program (or qualifies through a State's Medicaid waiver), (B) has no health insurance, (C) are American Indians or Alaskan natives, (D) has health insurance that does not pay for vaccinations (only applicable to FQHCs or RHCs), or (E) are none of the above. I/We will provide this information on the form entitled PROVIDER PROFILE (other side) as part of the procedure to enroll in the Connecticut VFC Program to receive publicly purchased vaccines.
2. I/We will administer VFC vaccines only to children in eligible age cohorts for each vaccine, as set by the Advisory Committee on Immunization Practices (ACIP) in VFC resolutions.
3. I/We will comply with the current immunization schedule, dosage, and contraindications, that are established by the DHHS Advisory Committee on Immunization Practices (ACIP) or the Report of the Committee on Infectious Diseases of the AAP, unless (a) in my medical judgement, and in accordance with accepted medical practice, I deem such compliance to be medically inappropriate; or (b) the particular requirement contradicts the Connecticut law, including Connecticut laws relating to religious or other exemptions.
4. I/We will distribute vaccine information materials and maintain records in accordance with the National Childhood Vaccine Injury Compensation Act, and that this information will be retained for a **ten (10) years** following the end of the calendar year the vaccine(s) were given.
5. I/We will provide a copy of the appropriate "Vaccine Information Statement" (VIS) forms to each vaccine recipient or legal guardian. I/We understand that these forms are designed to notify the vaccinee of the risk and benefits associated with receiving the vaccine and may provide me/us liability protection in the event that the vaccinee suffers a severe adverse reaction to the vaccine. I/We further understand that these materials meet the requirements for providers of vaccines covered by the National Vaccine Injury Compensation Program. As required by federal law, I/we will record on the patient's permanent medical record (or in a permanent office log or file) for a period **10 years** following the end of the calendar year the information* listed below:
 - * Date vaccine is administered;
 - * Name, address, professional title and signature of person administering the vaccine. (This information may be recorded one time. Use a single sheet or as many sheets as needed to record the required identifying information regarding the individual(s) administering vaccine at the facility/practice. The sheet(s) will need to be maintained in the office and be retrievable on request by the Immunization Program. Thereafter, the signature of the individual administering the vaccine, which will be entered on the patient's permanent medical record, will serve to satisfy the requirements related to the identification of the individual administering the vaccine.);
 - * Manufacturer's name and lot number of the vaccine and the route and site the vaccine was administered (e.g. oral or IM, right thigh or left arm, etc).
6. I/We will maintain records of the authorized representative's responses (the Patient Eligibility Screening Record) for a period of **three (3) years**. Release of such records will be bound by the privacy protection of Federal Medicaid law. If requested, I/we will make such records available to the Connecticut Immunization Program or the U.S. Department of Health and Human Services (DHHS).
7. I/We will comply with the Immunization Program requirements for ordering vaccines and with other requirements as outlined on the Vaccine Order Form (VOF). I/We will report doses of vaccine administered by broad age categories and by dose number in the series on the order form provided by the Connecticut Immunization Program. I/We will maintain good vaccine handling and storage practices as outlined in the CDC document "Vaccine Management January, 2001". I/We will also report to the Immunization Program any vaccine wastage/loss.
8. I/We will report adverse reactions (reactions requiring medical attention) associated with vaccine. Report reactions to (860) 509-7929.
9. I/We will not impose a charge for the cost of the vaccine received through this program. I/We may, however, charge a *reasonable* administration fee *per dose* given, but these fees should not exceed the **\$16.00 per dose** fee cap established by the State Immunization Program. Out-of-pocket costs for well-child care that includes immunization should be kept to a minimum, and a provider using vaccines supplied through the VFC program **may not deny** services to a child whose family cannot pay an administration fee or make a donation to the provider. In addition, providers may not bill a third-party (e.g. an insurance company or Medicaid) for vaccines already purchased with public (including VFC) funds. For the purposes of this agreement, multiple antigen vaccines such as MMR, Td, and DTaP are considered to be one vaccine. Polio vaccine is also considered to be a single vaccine regardless of the number of poliovirus types it contains. In the event that the vaccine recipient is a Title XIX (Medicaid) recipient, fee schedules established by the Department of Income Maintenance will prevail.
10. I/We understand that the Connecticut Immunization Program reserves the right to visit the facility. I/We will allow periodic inspections of vaccine supplies and records by the Connecticut Immunization Program.
11. Either the Connecticut Immunization Program may terminate this agreement at any time for failure to comply with these requirements or I/we may terminate this agreement for personal reasons.

Provider Signature

Date

This record is to be submitted to and kept on file at the Connecticut Immunization Program and must be updated at least once annually. A copy of this form will be retained at the provider's office. It will be shared with all relevant persons at the facility/practice including persons administering vaccines, staff responsible for billing procedures and any others determined at the provider site to need to know the information herein.