TEXAS VACCINES FOR CHILDREN PROGRAM (TVFC): PROVIDER ENROLLMENT

☐ Initial enrollment* ☐ Re-enrollment ☐ Provider PIN Number __ __ __ __ __ __

*Contact the Health Services Region (HSR) in your area to obtain PIN

Name of Facility, Practice, or Clinic: _____

Provider Name (M.D., D.O., N.P., P.A., or C.N.M.*): _____
(Last Name) (First Name) (MI) (Title)

Contact: _____
(Last Name) (First Name) (MI) (Title)

Mailing Address: _____
(P.O. Box or Street Address) (City) (Zip)

Address for Vaccine Delivery: _____
(Street Address and Suite Number) (City) (County) (Zip)

Telephone Number: (_____) _____–_____ Fax Number: (_____) _____–_____

E-mail Address: _____

In order to participate in the Texas Vaccines for Children Program and/or to receive federally- and state-supplied vaccines provided to me at no cost, I, on behalf of myself and any and all practitioners associated with this medical office, group practice, health department, community/migrant/rural health clinic, or other organization, agree to the following:

1) This office/facility will screen patients for VFC eligibility at all immunization encounters, and administer VFC-purchased vaccine only to children 18 years of age or younger who meet one or more of the following criteria: (1) Is an American Indian or Alaska Native; (2) is enrolled in Medicaid; (3) has no health insurance; (4) is underinsured: children who have commercial (private) health insurance but the coverage does not include vaccines, children whose insurance covers only selected vaccines (VFC- eligible for non-covered vaccines only), children whose insurance caps vaccine coverage at a certain amount (once that coverage amount is reached, these children are categorized as underinsured), or has insurance with a co-pay or deductible the family cannot meet, (5) is a patient who receives benefits from the Children's Health Insurance Plan (CHIP); (6) is a patient who is served by any type of public health clinic and does not meet any of the above criteria.
2) This office/facility will maintain all records related to the VFC program, including parent/guardian/authorized representative's responses on the Patient Eligibility Screening Form for at least three years. If requested, this office/facility will make such records available to the Texas Department of State Health Services (DSHS), the local health department/authority, or the U.S. Department of Health and Human Services.
3) This office/facility will comply with the appropriate vaccination schedule, dosage, and contraindications, as established by the Advisory Committee on Immunization Practices, unless (a) in making a medical judgment in accordance with accepted medical practice, this office/facility deems such compliance to be medically inappropriate, or (b) the particular requirement is not in compliance with Texas Law, including laws relating to religious and medical exemptions.
4) This office/facility will provide Vaccine Information Statements (VIS) to the responsible adult, parent, or guardian and maintain records in accordance with the National Childhood Vaccine Injury Act which include reporting clinically significant adverse events to the Vaccine Adverse Event Reporting System (VAERS). Signatures are required for informed consent. (The Texas Addendum portion of the VIS may be used to document informed consent.)
5) This office/facility will not charge for vaccines supplied by DSHS and administered to a child who is eligible for the TVFC.
6) This office/facility may charge a vaccine administration fee to non-Medicaid VFC-eligible patients not to exceed $14.85. Medicaid patients cannot be charged for the vaccine, administration of vaccine, or an office visit associated with Medicaid services. For Medicaid patients, this office/facility agrees to accept the reimbursement for immunization administration set by the state Medicaid agency or the contracted Medicaid health plans.
7) This office/facility will not deny administration of a TVFC vaccine to a child because of the inability of the child's parent or guardian/individual of record to pay an administrative fee.
8) This office/facility will comply with the State's requirements for ordering vaccine and other requirements as described by DSHS, and operate within the VFC program in a manner intended to avoid fraud and abuse.
9) This office/facility or the State may terminate this agreement at any time for failure to comply with these requirements. If the agreement is terminated for any reason this office/facility agrees to properly return any unused vaccine.
10) This office/facility will allow DSHS (or its contractors) to conduct on-site visits as required by VFC regulations.

_____ _____
(Signature*) (Date)

_____
(Print Name and Title)

* A licensed Medical Doctor, Doctor of Osteopathy, Nurse Practitioner, Physician Assistant, or a Certified Nurse Midwife must sign the TVFC Enrollment form.

TEXAS VACCINES FOR CHILDREN PROGRAM

PROVIDER PROFILE FOR PIN ___ ___ ___ ___ ___ ___

Is your facility a Federally Qualified Health Center, Migrant Health Clinic, or Rural Health Clinic?
(Circle one) YES NO

Type of Clinic: (√ check one)

- ☐ Public Health Department/District
- ☐ Public Hospital
- ☐ Other Public Clinic
- ☐ Private Hospital
- ☐ Private Practice (Individual or Group)
- ☐ Other Private Clinic

PATIENT PROFILE:

Please enter the number of children for each of the following categories and by age group who will be vaccinated at your clinic in the next 12-month period.

NUMBER OF CHILDREN IN EACH CATEGORY	< 1 year old	1 - 6 years	7 - 18 years	Total
Enrolled in Medicaid.				
Uninsured. *(Note: Children enrolled in Health Maintenance Organizations are considered insured)*				
American Indians.				
Alaskan Natives.				
Underinsured. (Has health insurance that **Does Not** pay for vaccines, has a co-pay or deductible the family cannot meet, or has insurance that provides limited wellness or prevention coverage.)				
(For Public Health Clinic Use ONLY) Children who do not meet any of the above criteria, but still receive vaccinations at **public health clinics.**				
Children who receive benefits from the Children's Health Insurance Plan (CHIP).				
Children who are vaccinated in your practice, but are **NOT** TVFC-eligible.				
TOTAL PATIENTS: (Add columns)				

TEXAS VACCINES FOR CHILDREN PROGRAM PROVIDER LIST

Please list all individuals within the practice who will be administering TVFC supplied vaccine.

Last Name (List provider who signed Provider Enrollment Formfirst)	First Name	Middle Initial	Title (M.D., D.O., N.P., P.A., R.N., L.V.N., M.A.)	National Provider Identification	Medical License Number	Specialty (Family Medicine, Pediatrics, etc.)

TEXAS VACCINES FOR CHILDREN PROGRAM

PROVIDER LIST-ADDENDUM FOR PIN ___ ___ ___ ___ ___ ___

Please list all individuals within the practice who will be administering TVFC supplied vaccine.

Last Name (List provider who signed Provider Enrollment Form first)	First Name	Middle Initial	Title (M.D., D.O., N.P., P.A., R.N., L.V.N., M.A.)	National Provider Identification	Medical License Number	Specialty (Family Medicine, Pediatrics, etc.)