IOWA | Health and Human Services
Public Health

Iowa Department of Health and Human Services Vaccines for Adults (VFA) Program Provider Agreement

FACILITY INFORMATION

Facility Name:		Organization NPI:	VFA PIN: (HHS only):
Facility Address:			
City:	County:	State:	Zip:
Shipping Address *(if different than facility address)*:			
City:	County:	State:	Zip:
Telephone:	Email:		

MEDICAL DIRECTOR OR EQUIVALENT

Instructions: *The official VFA-registered health care provider signing the agreement must be a practitioner authorized to administer vaccines under state law, who will also be held accountable for compliance by the entire organization and its VFA Program providers with the responsible conditions outlined in the provider enrollment agreement. The individual listed here must sign the provider agreement. Individuals with the following credentials can be listed as the Medical Director MD, DO, NP, PA, PharmD, RPh.*

Last Name, First, MI:	Title:	Specialty:
License Number:	Medicaid or NPI Number:	Employer Identification Number (optional):
Provide Information for second individual as needed		
Last Name, First, MI:	Title:	Specialty:
License Number:	Medicaid or NPI Number:	Employer Identification Number (optional):

VFA PROGRAM VACCINE COORDINATORS

Instructions: Each VFA Program provider must designate one staff member as the primary vaccine coordinator and at least one back-up coordinator who is able to perform the same responsibilities as the primary vaccine coordinator. These positions shall be responsible for oversight of vaccine management within the facility and serve as the VFA Program contact for the office.

Primary Vaccine Coordinator Name:	
Telephone:	Email:
Completed annual training: *(completion of the CDC web-based module) You Call the Shots Vaccine Storage and Handling* ◯ Yes ◯ No	
Backup Vaccine Coordinator Name:	
Telephone:	Email:
Completed annual training: *(completion of the CDC web-based module) You Call the Shots Vaccine Storage and Handling* ◯ Yes ◯ No	

PROVIDERS PRACTICING AT THE FACILITY **(Leave blank if not applicable)**

Instructions: *List below all licensed health care providers (MD, DO, NP, PA, PharmD, RPh) at your facility who have prescribing authority.*

Provider Name	**Title**	**License No.**	**Medicaid or NPI No.**	**EIN** (Optional)

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 health care facility of which I am the medical director or practice administrator or equivalent:	
1.	I will annually submit a provider profile representing populations served by my practice/facility.
2.	I will screen patients and document eligibility status at each immunization encounter and administer Vaccines for Adult vaccines only to adults who are at least 19 years of age and meet one of the following categories: a) Uninsured: A person who does not have health insurance. b) Underinsured: A person who has health insurance, but the coverage does not include vaccines; a person whose insurance covers only selected vaccines; a person whose insurance does not include first-dollar coverage for a vaccine.
3.	I will comply with immunization schedules, dosages, and contraindications that are established by the Advisory Committee on Immunization Practices (ACIP) unless: a) In the provider's medical judgment, and in accordance with accepted medical practice, the provider deems such compliance to be medically inappropriate for the person; b) The particular requirements contradict state law, including laws pertaining to religious and other exemptions.
4.	I will maintain all records related to the Vaccines for Adult Program for a minimum of three years and upon request make these records available for review. Vaccines for Adult records include, but are not limited to, 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 persons with publicly purchased vaccine at no charge to the patient for the cost of the vaccine.
6.	I will not charge a vaccine administration fee exceeding $19.68 per vaccine dose. I will not deny administration of a publicly purchased vaccine to an established patient because the individual of record is unable to pay the administration fee.

7.	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). Note: *For any ACIP recommended vaccine or immunization product that does not yet have a Vaccine (or Immunization) Information Statement available, a provider may use the manufacturer's package insert, written FAQs, or any other document – or produce their own information materials – to inform patients about the benefits and risks of that vaccine. Once a VIS is available it should be used; but providers should not delay use of a vaccine because of the absence of a VIS. If the vaccine is under an Emergency Use Authorization (EUA), the EUA Fact Sheet for Recipients should be made available.*
8.	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 Iowa HHS Immunization Program storage and handling recommendations and requirements as found on the department's website; d) Returning all spoiled/expired public vaccines to CDC's centralized vaccine distributor within six months of spoilage/expiration
9.	I agree to operate within the Vaccines for Adult 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 Vaccines for Adult Program a) 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. b) 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.
10.	I will participate in Vaccines for Adult Program compliance site visits including unannounced visits, and other educational opportunities associated with program requirements as recommended by the Iowa HHS Immunization Program.
11.	I agree to submit vaccine administration data for all publicly purchased vaccines using Section 317 and state/local funds to the jurisdiction's Immunization Information System (IIS), the Iowa Immunization Registry Information System.

12.	I understand this facility or the Iowa HHS Immunization 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 Iowa HHS Immunization Program.

By signing this form, I certify on behalf of myself and all immunization providers in this facility, I have read and agree to the Vaccines for Adult enrollment requirements listed above and understand I am accountable (and each listed provider is individually accountable) for compliance with these requirements.

Medical Director or Equivalent Name:	
Signature (a typed signature is acceptable):	Date:
Name of Second Individual (as needed):	
Signature (a typed signature is acceptable):	Date: