DEPARTMENT OF HEALTH SERVICES
Division of Public Health
F-02495 (09/2024)

STATE OF WISCONSIN

VACCINES FOR ADULTS (VFA) PROVIDER AGREEMENT

Please return the completed form to:
Division of Public Health, Wisconsin Immunization Program
By email at DHSVFA@wisconsin.gov
Or by fax at (608) 267-9493

FACILITY INFORMATION

Facility Name			
Street Address			
City	County	State	ZIP Code
Phone Number (include area code)	Fax Number (include area code)	State of WI Supplier ID, if known	
Mailing Address (if different than street address)			
City	County	State	ZIP Code

MEDICAL DIRECTOR OR AUTHORIZED DESIGNEE INFORMATION

Instructions: Under Wisconsin state law the signee of this provider agreement must be a practitioner authorized to administer vaccines, who will be held accountable for compliance by the entire organization, and its VFA providers to comply with the responsibilities outlined in this provider agreement.

The individual listed below **must** sign the provider agreement.

Medical Director – Name	Title	Specialty
License Number	Medicaid or NPI Number	Employer Identification No. (optional)
Authorized Designee – Name (if applicable)	Title	Specialty
License Number	Medicaid or NPI Number	Employer Identification Number

VFA VACCINE COORDINATOR INFORMATION

Primary Vaccine Coordinator – Name	Phone Number	Email
VFA/VFC Annual Training completed?	☐ Yes ☐ No	Type of Training Completed
Back-up Vaccine Coordinator – Name	Phone Number	Email
VFA/VFC Annual Training completed?	☐ Yes ☐ No	Type of Training Completed

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 equivalent.

1.	I will screen patients and document eligibility status at each immunization encounter and administer publicly purchased vaccines in accordance with the Immunization Policy and Procedures and 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 insurance does not include any vaccines; a person whose insurance covers only selected vaccines; a person whose insurance does not provide first-dollar coverage for vaccines.
2.	I will comply with immunization schedules, dosages, and contraindications that are established by the Advisory Committee on Immunization Practices (ACIP) except: 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 recipient. b. The particular requirements contradict state law, including laws pertaining to religious and other exemptions.
3.	I will maintain all records related to the VFA program for a minimum of three years and upon request make these records available for review. VFA records include, but are not limited to, VFA screening and eligibility documentation, billing records, medical records that verify receipt of vaccine, vaccine ordering records, and vaccine purchase and accountability records.
4.	I will not charge the patient an administration fee for VFA administered vaccine or for the cost of the vaccine.
5.	I will distribute the current Vaccine Information Statements (VIS) each time a vaccine is administered and maintain records in accordance with the National Vaccine Injury Compensation Program (NVICP), which includes reporting clinically significant adverse events to the Vaccine Adverse Event Reporting System (VAERS). COVID vaccines are covered under the Countermeasures Injury Compensation Program (CICP).
6.	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 Wisconsin Immunization Program storage and handling requirements. d. If boxes need to be split, vaccine must be stored in an amber type bag with the bag clearly marked with the vaccine type, lot number, expiration date and the NDC number from the box. e. Returning all spoiled/expired public vaccines to CDC's centralized vaccine distributor within six-month of spoilage/expiration
7.	I agree to operate within the VFA 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. **Fraud:** is an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him or some other person. It includes any act that constitutes fraud under applicable federal or state law. **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.

8.	I will participate in VFA program compliance site visit, including unannounced visits, and other educational opportunities associated with program requirements.
9.	I agree to replace vaccine purchased with federal funds (317) that are deemed non-viable due to provider negligence on a dose-for-dose basis.
10.	I agree to order vaccines through the Wisconsin Immunization Registry (or as directed by the Immunization Program), provide doses administered data by dose level to the Wisconsin Immunization Registry, and accept all vaccine transactions via the Wisconsin Immunization Registry and maintain inventory on hand within the Wisconsin Immunization Registry. Vaccines should be ordered under "adult".
11.	I understand this facility or the Wisconsin Immunization Program may terminate this agreement at anytime. If I choose to terminate this agreement, I will properly return any unused state provided vaccine as directed by the Wisconsin Immunization Program.
12.	I understand that data loggers are required and will be used in all refrigerators/freezers that contain state-supplied vaccine. Temperatures must be taken and documented daily with minimum and maximum temperatures recorded once a day in the morning. Data loggers should be cleared at the time of the morning reading. Data Loggers must be reviewed weekly and downloaded weekly or monthly.
13.	I understand that I must have at least one back-up data logger available for use in case a primary data logger breaks or malfunctions. I understand that it is best practice that the back-up data logger's expiration date is different than the primary data logger currently in use.

By signing below, I certify that I am authorized to sign on behalf of myself, all immunization providers in this facility, and this health care facility. I have read and understand the requirements above.

MEDICAL DIRECTOR OR AUTHORIZED DESIGNEE (if applicable)

SIGNATURE – Medical Director	Date Signed
Print Name of Medical Director	

SIGNATURE – Authorized Designee (if applicable)	Date Signed
Print Name of Authorized Designee	

PROVIDER PROFILE

All health care providers participating in Vaccines for Adults (VFA) must complete this form annually or more frequently if the number of adults served changes during the calendar year. VFA specialty providers may only order COVID-19 and influenza vaccine.

Date (mm/dd/yyyy)	**Provider Identification No (VFA or VFC PIN)**

FACILITY INFORMATION

Provider Name

Facility Name

Vaccine Delivery Address

City	State	ZIP Code

Phone Number (include area code)	Email

FACILITY TYPE (select facility type)

☐ **Private Facilities**

☐ Private Hospital
☐ Private Practice (solo/group/HMO)
☐ Private Practice (solo/groups as agent for FQHC/RHC-deputized)
☐ Community Health Center
☐ Pharmacy
☐ Other: _____

☐ **Public Facilities**

☐ Public Health Department Clinic
☐ FQHC/RHC (Community/Migrant/Rural)
☐ Community Health Center
☐ Tribal/Indian Health Services Clinic
☐ Women, Infants, and Children
☐ Other: _____

☐ STD/HIV
☐ Family Planning
☐ Correctional Facility
☐ Drug Treatment Facility
☐ Migrant Health Facility
☐ Refugee Health Facility

VFA VACCINES OFFERED (select the vaccine(s) that will be administered)
***** VFA specialty providers may only order COVID-19 and influenza vaccine.

☐ COVID-19*
☐ Influenza*
☐ Hepatitis A/B (Twinrix)
☐ HPV
☐ Hepatitis A
☐ Hepatitis B
☐ Meningococcal Conjugate
☐ MMR
☐ Pneumococcal Conjugate
☐ Pneumococcal Polysaccharide
☐ Polio
☐ RSV (only pregnant persons)
☐ Td
☐ Tdap
☐ Varicella

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