

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 annually submit a provider profile representing populations served by my practice/facility. I will submit more frequently if 1) the number of patients served changes or 2) the status of the facility changes during the calendar year.
2. I will screen patients and document eligibility status at each immunization encounter for Vaccines for Adults eligibility and administer publicly purchased vaccine by such category only to adults who are 19 years of age or older who meet one of the following categories:
 - A. Have no health insurance; or
 - B. Are underinsured: An adult who has health insurance, but the coverage does not include vaccines; an adult whose insurance covers only selected vaccines (eligible for non-covered vaccines only); or
 - C. Are fully insured and enrolled in or entering a post-secondary institution in New York State (eligible for MMR vaccine only).
3. For the vaccines identified and agreed upon in the provider profile, I will comply with immunization schedules, dosages, and contraindications that are established by the Advisory Committee on Immunization Practices (ACIP) and included in the Vaccines for Adults 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 for the child;
 - 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 Adults program for a minimum of three years and upon request make these records available for review. Vaccines for Adults 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 adults with publicly supplied vaccine at no charge to the patient for the vaccine. However, I may charge a reasonable administration fee.
6. I will not deny administration of a publicly purchased vaccine to an established patient because the patient 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).
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 New York State Department of Health storage and handling requirements;
 - 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 of Adults 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 Adults Program:

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.

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.
10. I will participate in Vaccines for Adults program compliance site visits including unannounced visits, and other educational opportunities associated with Vaccines for Adults program requirements.
11. I agree to replace vaccine purchased with state or federal funds that are deemed non-viable due to provider negligence on a dose-for-dose basis.

NEW YORK STATE DEPARTMENT OF HEALTH
Bureau of Immunization
Vaccine Program
ESP Corning Tower RM 649
Albany NY 12237-0627
Phone: (800) 543-7468 Fax: (518) 449-6912

FOR DOH USE ONLY Date rec'd: _____ PIN # _____

12. I will attempt to obtain consent from ALL adult patients for their immunizations to be reported to the New York State Immunization Information System (NYSIIS). I will report ALL doses administered according to Vaccines for Adults vaccine eligibility. Doses administered to adults who consent to NYSIIS will be reported to NYSIIS within two weeks of administration; doses administered to adults who do NOT consent to NYSIIS will be reported in the New York State Department of Health Vaccines for Adults Doses Administered Report by the 15th of each month.

I will use the NYSIIS Ordering Module to submit vaccine orders.

I will report vaccine inventory in NYSIIS and ensure that inventory reported with each order reflects current doses administered as reported in NYSIIS.

I will record twice daily temperatures in NYSIIS.

13. I understand this facility or the New York State Department of Health 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 New York State Department of Health.

FOR DOH USE ONLY Date rec'd: _____
PIN # _____

FACILITY TYPE (select facility type)

- Public Health Department Clinic
- Post-Secondary Institution
- Other _____

PROVIDER POPULATION

Provider Population based on patients seen during the previous 12 months. Report the number of adults 19 years of age and older who received vaccinations at your facility, by age group. Only count an adult **once** based on the status at the last immunization visit, regardless of the number of visits made. The following table documents how many adults received publicly funded vaccine, by category.

Public Vaccine Eligibility Categories	Number of post-secondary students who received MMR vaccine
No Health Insurance	
Underinsured ¹	
Have Health Insurance	
Total Publicly Funded Vaccine	

¹ Underinsured includes persons with health insurance that does not include vaccines or only covers specific vaccine types.

TYPE OF DATA USED TO DETERMINE PROVIDER POPULATION (choose all that apply)

- Benchmarking
- Medicaid Claims Data
- IIS
- Doses Administered
- Provider Encounter Data
- Billing System
- Other (must describe): _____

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 Adults 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 (print)

 Signature

 Date

 Name (print) Second Individual as Needed

 Signature

 Date