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Connecticut Vaccine for Adults (CVFA)

2024 CVFA Provider Agreement

FACILITY INFORMATION			
Facility Name:			PIN:
Facility Address:			
City:	County:	State:	Zip:
Telephone:		Fax:	
Shipping Address (*if different than facility address):*			
City:	County:	State:	Zip:

MEDICAL DIRECTOR OR EQUIVALENT		
Instructions: *The official 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 providers with the responsible conditions outlined in the provider enrollment agreement. The individual listed here must sign the provider agreement.*		
Last Name, First, MI:	Title:	Specialty:
License #:	Medicaid #:	National Provider Identifier # (NPI):
Provide Information for second individual as needed (for pharmacists only):		
Last Name, First, MI:	Title:	Specialty:
License #:	Medicaid #:	National Provider Identifier # (NPI) :

VACCINE COORDINATOR	
Primary Vaccine Coordinator* Name:	
Telephone:	Email: (NOTE: this email address will receive CVP communications)
Completed annual training: O Yes O No	Type of training received: a) Site visit b) CDC on-line modules c) Other/specify:
Back-Up Vaccine Coordinator* Name:	
Telephone:	Email: (NOTE: this email address will receive CVP communications)
Completed annual training: O Yes O No	Type of training received: a) Site visit b) CDC on-line modules c) Other/specify:

*The primary vaccine coordinator is the person at the office who has primary responsibility for ordering, monitoring, and ensuring the quality of vaccines at the practice; the back-up vaccine coordinator has responsibility in the vaccine coordinator's absence.

PROVIDERS PRACTICING AT THIS FACILITY *(additional spaces for providers at end of form)*

Instructions: *List below all licensed health care providers (MD, DO, NP, PA, pharmacist, APRN, RN, MA) at your facility who have prescribing or administering authority.*

Provider First and Last Name	Title	Prescribes	Administers	License #	Medicaid #	NPI#
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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 eligibility (i.e., federally or state vaccine-eligible) and administer vaccine by such category only to adults who are 19 years of age or older who are un-insured.
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 adult 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 patient; b) The particular requirements contradict state law, including laws pertaining to religious and other exemptions.
4.	I will maintain all records related to the vaccine program for a minimum of three years and upon request make these records available for review. Vaccine records include, but are not limited to, vaccine 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.
6.	I will not charge a vaccine administration fee to an uninsured patient that exceeds the administration fee cap of $21.00 per vaccine dose.

7.	I will not deny administration of a publicly purchased vaccine to an established patient because the patient of record is unable to pay the administration fee.
8.	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).
9.	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 CVP storage and handling requirements **including use of a data logger style thermometer for all CVP supplied vaccine**; d) Returning all spoiled/expired public vaccines to CDC's centralized vaccine distributor within **two** months of spoilage/expiration
10.	I agree to operate the adult vaccine 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 this 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. It also includes recipient practices that result in unnecessary cost to the Medicaid program.
11.	I will participate in CVP program compliance site visits including unannounced visits, and other educational opportunities associated with CVP program requirements.
12.	Should my staff, representative, or I access VTrckS, I agree to: a) Be bound by CDC's terms of use for interacting with the online ordering system. I further agree to be bound by any applicable federal laws, regulations or guidelines related to accessing a CDC system and ordering publically funded vaccines, and b) In advance of any VTrckS access by my staff, representative or myself, I will identify each member of my staff or representative who is authorized to order vaccines on my behalf. In addition, I will maintain a record of each staff member who is authorized to order vaccines on my behalf. If changes occur, I will inform the Connecticut Vaccine Program within 24 hours of any change in status of current staff members or representatives who are no longer authorized to order vaccines, or the addition of any new staff authorized to order on my behalf. I certify that my identification is represented correctly on this provider enrollment form.
13.	For pharmacies, urgent care, or school located vaccine clinics, I agree to: a) Vaccinate all "walk-in" eligible patients *b)* Not refuse to vaccinate eligible patients based on a patient's inability to pay the administration fee. Note: *"Walk-in" refers to any patient who presents requesting a vaccine; not just established patients. "Walk-in" does not mean that a provider must serve patients without an appointment. If a provider's office policy is for all patients to make an appointment to receive immunizations then the policy would apply to adult eligible patients as well.*
14.	I agree to replace vaccine purchased with state and federal funds that are deemed non-viable due to provider negligence on a dose-for-dose basis.

15.	I understand this facility or the Connecticut Vaccine Program may terminate this agreement at any time. If I choose to terminate this agreement, I will properly return any unused state and federal vaccine as directed by the Connecticut Vaccine 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 vaccine 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:

ADDITIONAL PROVIDERS

PROVIDERS PRACTICING AT THIS FACILITY *(additional spaces for providers at end of form)*

Instructions: *List below all licensed health care providers (MD, DO, NP, PA, pharmacist, APRN, RN, MA) at your facility who have prescribing or administering authority.*

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