NORTH CAROLINA VACCINES FOR ADULTS PROGRAM 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 North Carolina Vaccines for Adults (VFA) 317 Program 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 North Carolina VFA Program providers with the responsible conditions outlined in the provider enrollment agreement. For the purposes of this agreement, a vaccine is defined as any vaccine or vaccine-like product recommended by the Advisory Committee on Immunization Practices (ACIP). The individual listed here must sign the provider agreement.*		
Last Name, First, MI:		Title:
Specialty:	NC License No:	NC Medicaid or NPI No:
Employer Identification Number:	Email:	

VFA PROGRAM VACCINE COORDINATOR	
Primary Vaccine Coordinator Name:	
Telephone:	Email:
Completed annual training (within last 12 months): ○ Yes ○ No	Type/date of training received:
Back-Up Vaccine Coordinator Name:	
Telephone:	Email:
Completed annual training (within last 12 months): ○ Yes ○ No	Type/date of training received:

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) at your facility who have prescribing authority.*

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

PROVIDER AGREEMENT

To receive publicly funded VFA/317 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. 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 and administer publicly purchased and VFA/317 vaccines only to adults who are at least 19 years of age and meet the criteria specified in the North Carolina Coverage Criteria and supplement.
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 North Carolina 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 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 North Carolina Vaccines for Adults Program for a minimum of three years, or longer if required by state law, and upon request make these records available for review. North Carolina Vaccines for Adults Program records include, but are not limited to, North Carolina VFA Program 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 administer vaccine to eligible persons with publicly purchased vaccine at no charge to the patient for the cost of the vaccine.
6.	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) or Emergency Use Authorization (EUA) fact sheet (if applicable) 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 North Carolina Immunization Program storage and handling recommendations and 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 North Carolina Vaccines for 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 North Carolina 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. It also includes recipient practices that result in unnecessary cost to the Medicaid program.
10.	I will participate in the North Carolina Vaccines for Adults Program compliance site visits including unannounced visits, and other educational opportunities associated with the North Carolina Vaccines for Adults Program requirements as recommended by North Carolina Immunization Program.
11a.	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) in accordance with the North Carolina Immunization Program's regulations and reporting timelines.
11b.	I agree to submit vaccine administration data for all Vaccines for Adults Program purchased vaccines to the jurisdiction's Immunization Information System (IIS) in accordance with CDC documentation and data requirements.
13.	I understand this facility or the North Carolina 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 North Carolina 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 North Carolina Vaccines for Adults Program 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:

ADDITIONAL PROVIDERS

PROVIDERS PRACTICING AT THIS FACILITY *(attach additional pages as necessary)*

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

Provider Name	Title	NC License No.	NC Medicaid or NPI No.	EIN (optional)

North Carolina Vaccines for Adults Program
Provider Profile Form

All healthcare providers participating in the North Carolina Vaccines for Adults Program must complete this form annually or more frequently if the number of eligible adults served changes or the status of the facility changes during the calendar year.

Date: _____ /_____/ _____ **Provider Identification Number#_____**

FACILITY INFORMATION		
Provider's Name:		
Facility Name:		
Vaccine Delivery Address:		
City:	**State:**	**Zip:**
Telephone:	**Email:**	

FACILITY TYPE (select facility type)

☐ **Private Facilities**	☐ **Public Facilities**	
☐ Private Hospital	☐ Public Health Department Clinic	☐ Woman Infants and Children
☐ Private Practice (solo/group/HMO)	☐ Public Hospital	☐ STD/HIV
☐ Community Health Center	☐ FQHC/RHC (Community/Migrant/Rural)	☐ Family Planning
☐ Pharmacy	☐ FQHC Look-Alikes	☐ Correctional Facility
☐ Other_____	☐ Tribal Health Centers	☐ Drug Treatment Facility
	☐ Indian Health Services (IHS) Centers	☐ Migrant Health Facility
	☐ Community Health Center	☐ Refugee Health Facility
	☐ Tribal/Indian Health Services Clinic (Urban)	
	☐ Other_____	

PROVIDER POPULATION

Provider Population is based on patients seen during the previous 12 months. *Report the number of eligible adults who received vaccinations at your facility, by age group. Only count an adult <u>once</u> based on the status at the last immunization visit, regardless of the number of visits made. The following table documents the number of eligible adults who received publicly funded vaccines by category and the number of adults who received privately purchased vaccines.*

Publicly Funded Vaccine Eligibility Categories	# of individuals who received publicly purchased vaccines by age category			
	19 – 34 Years	35 – 49 Years	50+ Years	Total
American Indian/Alaska Native[1]				
No Health Insurance				
Underinsured[2]				
Incarcerated				
Total Publicly Funded Vaccine:				
Privately Purchased Vaccine	**# of individuals who received non-publicly purchased vaccines by age category**			
	19 – 34 Years	**35 – 49 Years**	**50+ Years**	**Total**
Insured (private pay/health insurance covers vaccines)				
Total Privately Purchased Vaccine:				
Total Patients (must equal sum of Total Publicly Funded + Total Privately Purchased)				

[1]American Indian and Alaska Native patients whose only source of healthcare is provided by an Indian Health Service, Tribal, or Urban Indian healthcare organization are not considered fully insured and may be vaccinated with 317-funded vaccines if the Indian Health Service, Tribal, or Urban Indian healthcare organization does not provide certain vaccines.

[2] 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.

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

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

NORTH CAROLINA VACCINES FOR ADULTS ("VFA") PROGRAM PROVIDER AGREEMENT - NCIR

The purpose of this agreement is to allow _____ to utilize the North Carolina Immunization Registry (NCIR) and fulfill all North Carolina Immunization Program ("NCIP") program requirements and participate in the North Carolina Vaccines for Adults ("VFA") program. The conditions of the agreement listed below are effective from the date the agreement is signed until renewal/reenrollment.

A. The provider signing this agreement shall be willing and able to:

1. Follow all NCIP program requirements, policies, and procedures, and participate in site visits and educational opportunities.
2. Be open at least four (4) consecutive hours on a day other than a Monday to receive state supplied vaccines.
3. Screen and document NCIP eligibility status with each immunization visit.
4. Administer vaccines provided through the North Carolina Immunization Program to eligible patients, following all Advisory Committee on Immunization Practices (ACIP) guidelines, according to the most relevant NCIP Coverage Criteria, and agree not to charge a third- party for the cost of vaccine.
5. Agree administration fees are per vaccine and not per antigen. Charge no administration fees for uninsured or underinsured patients with family incomes below two hundred percent (200%) of the federal poverty level. If not collected during the vaccine encounter, only one single bill may be issued for an administration fee within 90 days of the vaccine administration. Unpaid administration fees may not be sent to collections. Waive the administration fee if the eligible patient is unable to pay the administration fee.
6. Impose no condition or cost, such as a well visit, as a prerequisite to receiving vaccines. Charge no office fee in addition to the administration fee for an immunization–only or walk-in visit.
7. Record all required fields in NCIR for each dose of vaccine administered.
8. Provide a signed immunization record, at no charge, to the parent, guardian, or patient each time an immunization is given as specified in G.S. 130A-154 and when needed for schools, childcare facilities, colleges/universities, or wherever immunization records are required. Keep immunization records, either electronically or in paper form, according to the retention of medical records position statement of the North Carolina Medical Board (https://www.ncmedboard.org/resources-information/professional-resources/laws-rules-position-statements/position-statements/medical-records-documentation-electronic-health-records-access-and-retentio).
9. Share immunization data upon request as specified in G.S. 130A-153 and 10A NCAC 41A .0406.
10. Assume responsibility for the receipt, storage, management, administration, and transport of vaccine and all staff involved in these activities.
11. Ensure all current and new staff are fully trained in vaccine ordering, storing, handling, administration, use of the NCIR, reporting guidelines, and transportation of vaccine in an emergency annually or more often as needed. Provide documentation (i.e. training roster or log sheet) of training participants and dates upon request of NCIP.
12. Assume accountability for all state supplied vaccines received by your practice/agency:
    a. Complete a physical inventory of all state-supplied vaccine at least weekly and properly reconcile with the NCIR at least monthly (including assessing errors for providers participating in two-way data exchange with NCIR), with the recommendation of bi-weekly.
    b. Electronically record all state supplied and privately purchased vaccines into the NCIR at the time of administration or by the close of business the day the immunization is given, which meets the reporting requirement in G.S. 130A-153(b).
    c. Follow the NCIP Borrowing Policy, including limiting borrowing of state supplied vaccines to rare occurrences, completing the Vaccine Borrowing Form for all borrowing instances, and replacing borrowed vaccine within 30 calendar days. Planned borrowing of VFA vaccine, including the use of VFA vaccine as a replacement system for the provider's privately purchased vaccine inventory is not permissible.
    d. Do not share or transfer VFA vaccines to providers not enrolled with the VFA programs. Vaccine transfers are required to be approved by the NCIP in writing.
13. Report all adverse events as they occur through the Vaccine Adverse Events Reporting System (VAERS) electronically. For a complete list of required reportable events go to: http://www.vaers.hhs.gov/reportable.htm. Add an appropriate client comment in NCIR.
14. Providers are required to have two separate vaccine inventories: (1) VFA/317 vaccines, and (2) privately purchased vaccines (for privately insured patients). Providers must store, monitor, and maintain all vaccine stock under the same requirements as outlined in the most recent *NCIP Minimum Required Vaccine Ordering, Handling and Storage Procedures* (https://immunization.dph.ncdhhs.gov/providers/storageandhandling.htm), including the use of appropriate storage equipment.
15. The provider is subject to the most current NCIP Financial Restitution Policy (https://covid19.ncdhhs.gov/ncip-financial-restitution-policy/open) if vaccines are found to be wasted or spoiled due to the provider's negligence and/or failure to properly rotate, handle, or store the vaccine.
16. Notify NCIP thirty calendar days prior to a change in the provider or the employment or role of the individual who signed this agreement on behalf of the provider. If a change occurs with less than thirty calendar days' notice to the

provider's office, notify NCIP the same day the provider becomes aware.

17. Notify NCIP immediately when there are changes to the vaccine coordinator or back-up vaccine coordinator, a change in the facility shipping and mailing address, or if the status of the individual signing the Provider Agreement changes.
18. Ensure that email addresses for the vaccine coordinator, back-up vaccine coordinator, and provider are kept up-to-date and monitored for NCIP communications (including reviewing announcements posted on NCIR).
19. Report all suspected or confirmed cases of vaccine preventable diseases to the local health department within 24 hours as specified in GS 130A-135 and 10A NCAC 41A .0101.

B. With respect to the North Carolina Immunization Registry (NCIR), the provider signing this agreement shall:

1. Designate a minimum of two NCIR Administrators, with active, up-to-date agency internet email addresses, to ensure that the access level for each user does not exceed that individual's role in the agency and that access is only within the user's scope of work. Deactivate all users immediately when they leave the practice or are assigned to different duties within the organization that do not require NCIR access.
2. Require all users accessing NCIR under your authority to sign a *User Confidentiality Agreement* if they do not currently have one on file at your facility. The agreement must be made available to NCIP upon request.
3. Maintain and protect the confidentiality of information contained in NCIR in accordance with applicable North Carolina state and federal law as well as the requirements set forth in the NC DHHS Privacy and Security Manuals (https://policies.ncdhhs.gov/departmental/policies-manuals/section-viii-privacy-and-security/) and the NC Statewide Information Security Manual (https://it.nc.gov/statewide-information-security-policies).
4. Assume responsibility for all organization users accessing NCIR under your authority. Ensure all current and new staff receive NCIR training, agree to not share NCIR user IDs and/or passwords or other credentials with any other individual, and protect the confidentiality and integrity of the information contained in NCIR in accordance with this agreement and applicable law.
5. Provide NCIP with notice of all suspected and confirmed privacy/security incidents or privacy/security breaches involving unauthorized access, use, disclosure, modification, or destruction of the information retained in NCIR, including a breach of account credentials or user permissions. Notice shall be provided within twenty-four (24) hours after the incident is first discovered by submitting a report at: https://security.ncdhhs.gov/.
6. As much as possible, assure that all patient names entered into the NCIR reflect the patient's true, legally documented, complete name (e.g. from the birth certificate).
7. Ensure your facility has a contingency plan in place for use during periods of internal internet disruption and/or NCIR outages.
8. Acknowledge and agree that the NCIR does not make medical decisions and is not a substitute for competent, properly trained, and knowledgeable staff who bring professional judgment and analysis to the information presented by the software. All medical treatment and diagnostic decisions provided are the sole responsibility of the provider.

NCIP or the provider may terminate this agreement at any time for personal reasons or failure to comply with conditions of this Agreement. The provider is required to comply with any additional VFA Program requirements as the CDC or NCIP may from time to time impose. Upon termination, the provider must properly store, handle, and return all viable, unused NCIP vaccine within 30 calendar days of termination. Failure to comply with all VFA and NCIP requirements may result in suspension or termination from the program. Individuals and facilities on the "List of Excluded Individuals and Entities" published by the federal Department of Health and Human Services Office of the Inspector General ("exclusion list") are prohibited from participating in federally funded health care programs including the VFA Program. The provider represents it is not currently on the exclusion list and will immediately notify NCIP if placed on the exclusion list.

I understand the terms of this agreement and agree to comply with this agreement and all applicable statutes, rules/regulations, and requirements.

Provider's Signature (DO NOT USE A STAMP)	Provider's Name (PRINT OR STAMP)	Federal Tax ID	Provider's NC License #	Date

INSTRUCTIONS PURPOSE:

This document constitutes a legal agreement under which NCIP may provide vaccines to a private provider to immunize patients and access to the North Carolina Immunization Registry.

PREPARATION:

1. Prepare an original and a copy.
2. Print or type the practice's name.
3. The signature must be of an individual with signatory authority for the Provider.
   a. The provider in a group practice must be authorized to administer pediatric vaccines under state law to sign the Provider Agreement.
   b. The provider signing the Provider Agreement on behalf of a multi-provider practice must have authority to sign on behalf of the entity. That provider will be held accountable for the entire organization's compliance, including site visit participation and educational requirements.
4. The provider's signature must be an original; a stamp is not acceptable.
5. The agreement shall be available for review by NCIP personnel.

DISTRIBUTION:

1. Mail, fax, or email agreement to:

   NCDHHS, Division of Public Health
   Immunization Branch
   1917 Mail Service Center
   Raleigh, North Carolina 27699-1917

   Fax: 1-800-544 3058

   Email: ncirhelp@dhhs.nc.gov

2. Retain a copy for your records.

DISPOSITION:

Completed (signed and dated) form must be retained during participation in the NCIP/VFA program and for six years from the date this agreement is terminated. If a notice of a claim or lawsuit has been made, this agreement(s) should be retained until after final disposition of the claim or litigation (including appeals).

SUPPORTING DOCUMENTS:

Supporting documents, additional forms, and NCDHHS, DPH, Immunization Branch policies may be obtained at http://www.immunize.nc.gov/ or by calling 1- 877-873-6247.