New Jersey Department of Health
Vaccines for Children (NJVFC) Program
P.O. Box 369
Trenton, NJ 08625-0369
Phone: (609) 826-4862 Fax: (609) 826-4868

NEW PROVIDER ENROLLMENT FOR ADULT SITE

INSTRUCTIONS: *Email completed New Provider Enrollment for Adult Site and New Provider Agreement for Adult Site to: VFC@doh.nj.gov.*

Today's Date *(MM/DD/YYYY)*
__ __ / __ __ / __ __ __ __

PROVIDER INFORMATION

Office Name:

Office Medicaid Number: | Office NPI Number: | Office Tax ID:

Provider Type:

Private Facilities: ☐ Not for Profit Clinic *(Proof of not for profit status must be sent with this enrollment.)*

Public Facilities: ☐ Public Health Department ☐ Federally Qualified Health Center

Vaccines Offered *(Select only one box)***:**

☐ All ACIP Recommended Vaccines for Adults

☐ Offers Select Vaccines ***(This option is only available for facilities designated as "Specialty Providers" by the 317 Program.)***

A "Specialty Provider" is defined as a provider that only serves (1) a defined population due to the practice specialty (e.g., OB/GYN, STD clinic, family planning) or (2) a specific age group within the general population of adults ages 19+. Local health departments are not considered specialty providers. The 317 Program has the authority to designate 317 providers as specialty providers.

Select Vaccines Offered by Specialty Provider:

☐ Hepatitis A/B	☐ Meningococcal Conjugate	☐ TD
☐ HPV	☐ MMR	☐ Tdap
☐ Influenza	☐ Pneumococcal Conjugate	☐ Varicella
☐ Men B	☐ Pneumococcal Polysaccharide	☐ Zoster

☐ Other *(specify)*:

Vaccine Delivery Address

Address 1: | Address 2:

City: | State: NJ | Zip:

County: | Municipality:

Phone: ( ) | Ext. | Fax: ( )

Email:

LICENSED MEDICAL PROVIDERS

The Medical Director signing this agreement must be authorized to administer adult vaccines under state law. The Medical Director will be held accountable for 317-Funded Adult Program compliance by the entire organization with all items stated in the Provider Agreement for adult sites.

1. Medical Director | Title: ☐ MD ☐ DO | Date of Birth:

Last Name: | First Name: | Middle Name:

NPI No.: | Medical License No.: | Medicaid No.:

2. Licensed Medical Provider | Title: ☐ MD ☐ DO ☐ PA ☐ NP | Date of Birth:

Last Name: | First Name: | Middle Name:

NPI No.: | Medical License No.: | Medicaid No.:

NEW PROVIDER ENROLLMENT FOR ADULT SITE
(Continued)

LICENSED MEDICAL PROVIDERS, CONTINUED

3. Licensed Medical Provider Title: ☐ MD ☐ DO ☐ PA ☐ NP Date of Birth:

Last Name: First Name: Middle Name:

NPI No.: Medical License No.: Medicaid No.:

4. Licensed Medical Provider Title: ☐ MD ☐ DO ☐ PA ☐ NP Date of Birth:

Last Name: First Name: Middle Name:

NPI No.: Medical License No.: Medicaid No.:

ASSOCIATED ADDITIONAL MEDICAL OFFICES

(Complete this section only if there are other offices in the practice. If none, go to next section.)

1. Medical Office Name: VFC Pin:

Street 1: Street 2:

City: State: NJ Zip:

County: Municipality:

Phone: ( ) Ext. Fax: ( )

2. Medical Office Name: VFC Pin:

Street 1: Street 2:

City: State: NJ Zip:

County: Municipality:

Phone: ( ) Ext. Fax: ( )

ADULT SITE CONTACTS

Two designated on-site and fully trained staff responsible for all vaccine management activities within the practice.

Primary Vaccine Coordinator:

Last Name: First Name: Middle Name:

Email: Phone: Ext.

Backup Vaccine Coordinator:

Last Name: First Name: Middle Name:

Email: Phone: Ext.

NEW PROVIDER ENROLLMENT FOR ADULT SITE
(Continued)

VACCINE DELIVERY HOURS
(Hours when vaccine shipments can be delivered. Exclude lunch hours if office is closed. Note: No deliveries are made on Mondays.)

☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

From (hh:mm): ____ : ____ To (hh:mm): ____ : ____ AND

From (hh:mm): ____ : ____ To (hh:mm): ____ : ____

☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

From (hh:mm): ____ : ____ To (hh:mm): ____ : ____ AND

From (hh:mm): ____ : ____ To (hh:mm): ____ : ____

☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

From (hh:mm): ____ : ____ To (hh:mm): ____ : ____ AND

From (hh:mm): ____ : ____ To (hh:mm): ____ : ____

Special Delivery Instructions: ____

NATIONAL INSTITUTE OF STANDARDS AND TECHNOLOGY (NIST) THERMOMETERS
(Enter only one Certification Number for dual probe thermometer Certificates.)

Thermometers:

1. Type:	☐ Data Logger ☐ Digital Min/Max Thermometer	Certification or Serial Number:		NIST Certification Expiration Date:	
2. Type:	☐ Data Logger ☐ Digital Min/Max Thermometer	Certification or Serial Number:		NIST Certification Expiration Date:	
3. Type:	☐ Data Logger ☐ Digital Min/Max Thermometer	Certification or Serial Number:		NIST Certification Expiration Date:	
4. Type:	☐ Data Logger ☐ Digital Min/Max Thermometer	Certification or Serial Number:		NIST Certification Expiration Date:	

Back-Up Thermometer *(Required)*:

1. Type:	☐ Data Logger ☐ Digital Min/Max Thermometer	Certification or Serial Number:		NIST Certification Expiration Date:	

NEW PROVIDER ENROLLMENT FOR ADULT SITE
(Continued)

PROVIDER POPULATION:

Provider population based on patients seen during the previous 12 months. Report the number of adults 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 317-funded vaccine, by category, and how many received non-317 vaccine.

	Number of Adults Who Received Vaccine by Age Category			
317 Vaccine Eligibility Categories	**19-29 years old**	**30-39 years old**	**40-59 years old**	**60+ years old**
• No Health Insurance				
• Underinsured [1]				
Non-317 Vaccine Eligibility Category	**19-29 years old**	**30-39 years old**	**40-59 years old**	**60+ years old**
• Health Insurance Pays Some/All Vaccine Cost				

[1] *Underinsured includes adults with health insurance that does not include vaccines or only covers specific vaccine types. Adults are only eligible for vaccines that are not covered by insurance.*

TYPE OF DATA USED TO DETERMINE PROVIDER POPULATION *(Choose ALL that apply):*

☐ Benchmarking ☐ Doses Administered
☐ Medicaid Claims Data ☐ Provider Encounter Data
☐ NJIIS ☐ Billing System
☐ Other *(must describe)*:

The Medical Director signing this agreement must be authorized to administer adult vaccines under state law. The Medical Director will be held accountable for 317-Funded Adult Program compliance by the entire organization with all items stated in the Provider Agreement for adult sites.

Print Name of Medical Director: | Signature of Medical Director: | Date:

FOR STATE USE ONLY										
Date Certified for NJVFC		Staff Name		PIN Number						
Federal HHS OIG Search Done	☐ Yes ☐ No	NJ Consumer Affairs OIG Search Done	☐ Yes ☐ No	Address Checked on USPS Site	☐ Yes ☐ No	Correction made to conform to USPS Address	☐ Yes ☐ No	Checked Not for Profit Status	☐ Yes ☐ No	
Document clarification of HHS OIG an NJ Division of Consumer Affairs issues here:										

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NEW PROVIDER AGREEMENT

FOR ADULT SITES

***Instructions**: Email the completed VFC New Provider Agreement for Adult Sites and the New Provider Enrollment for Adult Sites to: VFC@doh.nj.gov.*

Office Name	Office Medicaid Number

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 healthcare 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 adults 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 317-Funded Adult (317) Program eligibility and administer 317-purchased vaccine by such category only to adults who are 19 years of age or older who meet one or more of the following categories:
   - A. 317 vaccine-eligible adults:
     - (1) have no health insurance
     - (2) have health insurance that covers no part of the vaccine.
   - B. fully insured individuals seeking vaccines during identified public health response activities* including:
     - (1) outbreak response
     - (2) post-exposure prophylaxis
     - (3) disaster relief efforts
     - (4) mass vaccination campaigns or exercises for public health preparedness.

   ** Pre-approval must be obtained from the NJVFC Program prior to the use of 317-Funded vaccine for the above activities.*

   Individuals that do not meet one or more of the above eligibility categories are NOT eligible to receive 317-purchased vaccine.

   Note: Adults whose health insurance covers any portion of the cost of vaccine are not eligible for 317-purchased vaccines. This applies even when a claim for the cost of the vaccine and its administration would be denied for payment by the insurance carrier because the plan's deductible or co-pay had not been met.
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 317-Funded Adult Program unless:
   - A. In the provider's medical judgement, and in accordance with accepted medical practice, the provider deems such compliance to be medically inappropriate for the adult.
   - B. The particular requirements contradict state law, including laws pertaining to religious or other exemptions.
4. I will maintain all records related to the 317 Program for a minimum of three years and, upon request, make these records available for review. 317 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.
6. I will not charge a vaccine administration fee to 317-eligible adults that exceeds the administration fee cap of $24.23 per vaccine dose.
7. I will not deny administration of a publicly-purchased vaccine to an established patient because the individual 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 time. Refrigerator and freezer vaccine storage units and temperature monitoring equipment and practices must meet the New Jersey Vaccines for Children Program (NJVFC) storage and handling requirements.
   - D. Returning all spoiled/expired public vaccines to CDC's centralized vaccine distributor within six months of spoilage/expiration.
10. I agree to operate within the 317 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 317 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 317 Program compliance site visits, including unannounced visits, and other educational opportunities associated with 317 Program requirements.
12. 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.
13. Per N.J.A.C. 8:57-3.16, I understand that all providers administering vaccines to children less than 7 years of age must register as a provider with the New Jersey Immunization Information System (NJIIS) and report vaccinations online within 30 days. Additionally, I understand that the 317 Program requires every provider to enter all vaccinations given with 317-funded vaccine, into NJIIS within 30 days of administration (regardless of the age of the patient) and agree to comply with this mandate.
14. I understand this facility or the New Jersey Vaccines for Children Program which manages the 317-Funded Adult 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 317 Program.

By signing below, I acknowledge that I have read and accept the Provider Agreement.

Print Name of Medical Director:		Signature of Medical Director:		Date:	