



VFC NEW PROVIDER ENROLLMENT GUIDE 2024

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VACCINES FOR CHILDREN (VFC) PROGRAM

Program Overview

The Vaccines for Children (VFC) Program is a federally funded program that provides vaccines at no cost to children who might not otherwise be vaccinated because of an inability to afford vaccines.

Eligible Participants

Children who are 18 years and under and meet at least one of the following criteria are eligible to receive vaccines from the VFC program:

- AHCCCS enrolled - children who are eligible for the state Medicaid program;
- Uninsured - children not covered by any health insurance plan;
- American Indian/Alaska Native (AI/AN) - this population is defined by the Indian Health Care Improvement Act (25 U.S.C. 1603). AI/AN children are VFC eligible under any circumstance; or are
- Under-insured* - children who have private insurance that does not cover some or all Advisory Committee on Immunization Practices (ACIP) recommended vaccines.

*Federally Qualified Health Centers (FQHC), Rural Health Centers (RHC), county health departments, and approved deputized providers are the only providers allowed to serve the VFC eligibility category of underinsured.

VFC Program Providers

All new providers must complete the [VFC New Provider Enrollment Form](#) and be approved by the Bureau of Immunization Services (BIZS) to participate and administer VFC vaccines to eligible participants. This guide will assist new providers with completing the enrollment form.

VFC New Provider Enrollment Guide

This guide includes important information and detailed instructions with screenshots to help you complete your New Provider Enrollment Form.

NEW PROVIDER ENROLLMENT FORM

Submitting a New Provider Enrollment Form

- Review the information outlined in this document, and when ready to begin, go to <https://redcapaipo.azdhs.gov/surveys/?s=KJ38PFT994EMT7EE>.
- Utilize the step-by-step instructions included in this guide to help you properly complete your New Provider Enrollment Form.
- The process typically takes about 20 minutes but may take longer. You can save your information and access it later if you are unable to complete the enrollment form in one sitting.

Information Needed to Complete the New Provider Enrollment Form

a. Provider Contact/Facility Details

- Physical address where the vaccines will be administered, this must be the same as the delivery address.
- Mailing address for your practice.
- Contact details (listed below) for the primary vaccine coordinator, back-up vaccine coordinators, signatory physician, or office manager (if applicable).
 - First and Last Name
 - Email address
 - Direct telephone number
 - Fax number (if applicable)

b. Authorized Providers and Practice Details

- Physician must sign the Provider Agreement -AND - If pharmacists are administering vaccines under the direct supervision of a physician, both the pharmacist and the physician must sign the Provider Agreement.
- Provide the names, specialties, Arizona State Medical License Numbers, and National Provider IDs (NPI) for all licensed healthcare providers enrolled with the practice. Links to help you locate License Numbers:
 - [Arizona Medical License](#)
 - [Board of Nursing](#)
 - [Arizona Osteopathic Board](#)
 - [Arizona State Board of Pharmacy](#)
 - [National Provider ID \(NPI\)](#) (required for each physician/vaccinator)

c. Provider Details

- Days of the week and core business hours that staff is available to receive vaccine shipments.
 - o Provider **must be open for a minimum of four consecutive hours on a day other than Monday** to receive vaccines.
- Estimated number of children who will receive immunizations at your practice during the calendar year (January 1 through December 31 of the given year) by age group, insurance type, and demographics.
(Estimate if unknown)

d. Refrigerator/Freezer Verification Form and Equipment Requirements

- [Required storage units](#) for storing VFC Vaccines and [Digital data Loggers](#) used for monitoring temperatures must meet VFC requirements.
 - o A Digital Data logger is required and is the ONLY acceptable temperature monitoring device for all units storing VFC vaccines, including having a readily available back-up data logger.
- The Signatory Physician will initial and list the number of units in the corresponding box to indicate the type of units at your office where you will store VFC vaccines.
- The Signatory Physician is required to complete the verification form and provide an electronic signature.

e. Certificates for Completed Annual Training

- Primary and back-up vaccine coordinators must supply documentation of annual completion of one of the following available training options:
 - o CDC "You Call the Shots" (YCTS) Vaccines for Children (VFC) -OR-
 - o CDC "You Call the Shots" (YCTS) Vaccine Storage and Handling -OR-
 - o AIPO Train - Arizona Vaccines for Children Training

After a Completed Enrollment Form is Submitted

- Upon receipt of the completed enrollment form the Bureau of Immunization Services (BIZS) will process the application.
- The assigned Immunization Program Specialist (IPS) will reach out to the new location in 5-7 business days to schedule a required New Provider In-Service (NPIS) to examine the refrigerator/freezer data loggers and to train the provider office staff in VFC policies and procedures.
- Providers that comply with all aspects of the VFC program will be issued a VFC provider identification number (pin).

- Please **note the unique VFC pin assigned to your facility**. You will be asked for the pin for all correspondence, orders, and inquiries to the BIZS.
- The provider's office will be **required to place an order within three months of the new provider training** and, at a minimum, yearly.

After the New Provider In-Service (NPIS) is Complete

- Provide valid data logger calibration certificates for all units storing VFC vaccines and the back-up data logger.
- Complete and sign a [Vaccine Accountability and Management Plan](#).
- A compliance visit will be scheduled for 3-6 months.
 - Vaccines must be on hand and the provider should be administering vaccines within the first 3-6 months (at least to start).

Important Resources

- [Arizona Vaccines for Children \(VFC\) Program Operations Guide](#)
- [Arizona Immunization Program website](#)
- [VFC Vaccine Coordinator Annual Training Requirements](#)

Additional Considerations

- VFC vaccines must be delivered to the facility where they will be administered. The use of mobile units is limited to providers approved by the BIZS to operate mobile units to administer VFC vaccines.
- All parts of the agreement must be signed by the person within your practice who is licensed in the State of Arizona to prescribe vaccines (M.D., D.O., NP, or FNP) and who has primary responsibility for making decisions about your practice and its operations.

INSTRUCTIONS FOR COMPLETING A NEW PROVIDER ENROLLMENT FORM

When ready, go online to the [New Provider Enrollment Form](#)

- ❖ The New Provider Enrollment Form is comprised of six (6) individual forms. You must finish all six forms for your enrollment to be complete.
- ❖ You must complete all required fields in each form to proceed to the next form.
- ❖ The information you enter can be saved at the end of each form, if you need to stop before you have completed all six.

Form #1 of 6

ARIZONA DEPARTMENT OF HEALTH SERVICES

Arizona Vaccines for Children (VFC) New Provider Enrollment Form

This is form **1** of 6

This form should be used by providers wishing to enroll in the Vaccines For Children Program (VFC). For information about the VFC Program, click [here](#).

- [Click here to enroll in ASIS without becoming a VFC Provider.](#)
- [Click here if you are already a VFC provider and wish to update your facility information.](#)
- [Click here if you are already a VFC provider and wish to update the signatory physician.](#)

You must complete this form in one session. Before you begin, make sure you have ALL of the required documents available to upload.

FACILITY INFORMATION

Facility Name

The vaccines must be shipped to the location where they will be administered. It cannot be a mailing address.

Facility/Shipping Address:

City: County:

State: Zip:

Telephone: Fax:

Mailing Address:

City: County: State:

* must provide value

❖ Complete each field.

⚠ Facility name cannot be more than 35 characters.

⚠ The facility address must be where the vaccines will be administered and delivered.

Form #1 of 6 (continued)

MEDICAL DIRECTOR OR EQUIVALENT (M.D., D.O., NP)

Instructions: The official VFC registered health care provider who will administer pediatric vaccines under state law and its VFC providers with the responsible authority here must sign the provider agreement.

***Note:** For the purposes of the VFC program, the provider must be the ACIP-recommended product for which ACIP



This should be the individual (M.D., D.O., NP) who has primary responsibility for making decisions about your practice and its operations. This individual will be held accountable for compliance and will be the person who signs the provider agreement.

First Name:

Medical

Specialty:

License No.:

12345

Medicaid or NPI No.:

5432

Email:

example@email.com

23 characters remaining

Confirm email:

example@email.com

23 characters remaining

Employer Identification No. (optional):

Medical Director Employer Identifica

❖ Complete each field, no fields can be left blank.



Emails addresses cannot be more than 40 characters.

VFC VACCINE COORDINATORS

Primary Vaccine Coordinator

First Name:

Vaccine

Last Name:

Coordinator

Email:

coordinator@email.com

19 characters remaining

Confirm Email:

coordinator@email.com

19 characters remaining

Telephone:

(480) 123-4567

* must provide value

Annual training requirements completion:

Must have at least one of the following:

CDC You Call the Shots Vaccines for Children or Storage and Handling modules

The certificate must be dated in this current year

OR AIPO TRAIN modules

Arizona Vaccines for Children Training module

Expires one year from the date of training

Completion Date:

❖ Click the **upload file** link to attach one of the approved required annual trainings.

Training certificate: [Upload file](#)

* must provide value

Back-Up Vaccine Coordinator

First Name:

Back-Up

Last Name:

Coordinator

Email:

Back-Up@email.com

23 characters remaining

Confirm Email:

Back-Up@email.com

23 characters remaining

Telephone:

(480) 765-4321

* must provide value

Annual training requirements completion:

Must have at least one of the following:

CDC You Call the Shots Vaccines for Children or Storage and Handling modules

The certificate must be dated in this current year

OR AIPO TRAIN modules

Arizona Vaccines for Children Training module

Expires one year from the date of training

Completion Date:

M-D-Y * must provide value

Training certificate: [Upload file](#)

* must provide value

❖ Repeat the same process as above for the Back-Up Vaccine Coordinator.

❖ Once all information has been entered click the **Go to the Next Form** button.

Go to the Next Form

Status Home Page

⚠ You're not finished yet. The next required form is be not be reviewed until all forms are c

You have completed form 1 of 6. You are required to complet submission will not be reviewed.

Survey Queue

This is the **EXAMPLE FACILITY 1234 Example St.** survey queue page.

The signatory physician responsible for overseeing the vaccines, Medical Director (surveys) before the VFC application for **EXAMPLE FACILITY** can be reviewed. The signatory provider (Medical Director) knows the requirements. 2. Ensure the fac your submitted forms will be emailed to you separately once Bureau of Immuni have been completed. Please note that this email *does not* serve as approval of only.

Please click on the **"Begin Survey"** button below to complete the next form.

Status	Survey Title
Begin survey	Provider Agreement
Begin survey	Arizona Vaccines for Children (VFC) Refrigerator and Freezer V
Begin survey	Arizona Vaccines for Children (VFC) Program Provider Profile
Begin survey	Arizona Vaccines for Children (VFC) Program Prescribing Providers - #1
Begin survey	ASIS Users - #1

- ❖ Forms 2-6 are survey forms housed on this status page.
- ❖ All forms must be finished to complete enrollment.

[Get link to my survey queue](#)

📢 Click the *Get link to my survey queue* button to obtain a link that will allow you to return to your forms in the future.

- ❖ Click ***Begin survey*** to start each survey form.

Form #2 of 6 - Provider Agreement

PROVIDER AGREEMENT

To receive publicly funded vaccines at no cost, I agree to the following terms and conditions:

- I will annually submit a provider profile representing more frequently if:
 - The number of children served changes or
 - The status of the facility changes during the year.
- I will screen patients and document eligibility status as follows:
 - Federally Vaccine-eligible Children (VFC eligible):
 - Are you an American Indian or Alaska Native;
 - Are enrolled in Medicaid;
 - Have no health insurance;
 - Are underinsured: A child who has health insurance whose insurance covers only selected vaccines; children are eligible to receive VFC vaccine only at a State Health Clinic (SHC) or under an approved waiver.
 - State Vaccine-eligible Children:
 - In addition, to the extent that my state designates "eligible," I will screen for such eligibility as listed state-funded doses (including 277 funded doses).
- For the vaccines identified and agreed upon in the provider's medical judgment, and in accordance with the particular requirements contained in the state law, I will maintain all records related to the VFC program including, but not limited to, billing records, medical records that vaccine purchase and accountability records.
- I will immunize eligible children with publicly supplied vaccines.
- I will not charge a vaccine administration fee to non-Medicaid eligible children that exceeds the administrative fee cap of \$21.33 per vaccine dose. For Medicaid children, I will accept the reimbursement for immunization administration set by the state Medicaid agency or the contracted Medicaid health plans.
- I will not deny administration of a publicly purchased vaccine to an individual or individual of record is unable to pay the administrative fee cap of \$21.33 per vaccine dose.
- I will not deny administration of a publicly purchased vaccine to an individual or individual of record is unable to pay the administrative fee cap of \$21.33 per vaccine dose.
- I will participate in VFC pre-licensure opportunities associated with the program.
- For specialty providers, I agree to:
 - Vaccinate all "walk-in" patients who do not refuse to pay the administrative fee.
 - Refer "walk-in" patients to my office and not refer them to a third party to make an appointment. "Walk-in" may also include patients who are referred to my office by a third party.
- I agree to replace vaccine due to provider negligence.
- For providers with a signed deputation Memorandum of Understanding between a FQHC or RHC and the Arizona Vaccines for Children Program to serve underserved VFC-eligible children, I agree to:
 - Understand and agree to the terms of the deputation agreement.
 - Vaccinate "walk-in" patients who do not refuse to pay the administrative fee.
 - Refer "walk-in" patients to my office and not refer them to a third party to make an appointment. "Walk-in" may also include patients who are referred to my office by a third party.
- I will comply with all Arizona immunization laws, and shall register with the Arizona Immunization Registry (AIR) and ASIS (Arizona State Immunization System) by the deadline of 12/31/2024.
- I will be responsible for the the registry system. Staff will be responsible for the the registry system. Staff will be responsible for the the registry system.
- I will submit immunization information to ASIS via direct data entry or electronic reporting. Paper reporting is no longer an available option.


⚠ Form #2 must be signed by the individual (M.D., D.O., NP, or FNP) who has primary responsibility for making decisions about your practice and its operations.

- ❖ Carefully read each statement, 1-16. Ensure you understand and agree to each condition before signing the provider agreement.

Form #2 of 6 - Provider Agreement (continued)

By signing this form, I certify on behalf of myself and all immunization providers in the facility that I agree to the Vaccines for Children enrollment requirements listed above and understand that each listed provider is individually accountable for compliance with these requirements.


Medical Director or Equivalent Name: **Medical Director**

Medical Director or Equivalent Name Signature:  [Add signature](#)

Date: 06-17-2024  Today M-D-Y

* must provide value

❖ Click the **Add signature** link.

Medical Director or Equivalent Name Signature:  [Add signature](#)

* must provide value

SIGN HERE

Save signature reset

Go to the Next Form

⚠ A new window will pop up to enter your signature.

You're not finished yet!

Click the button below to go to the next form, this will save your progress.

Go to the Next Form

Save & Return Later

- ❖ Click **Go to the Next Form**, if ready to continue to complete the next survey form.
- ❖ Click **Save & Return Later**, to save and continue later.

Status Home Page

⚠ **You're not finished yet.** The next required form is below. Your submission will not be reviewed until all forms are complete.

You have completed form 2 of 6 You are required to complete *all* of the survey forms or your submission will not be reviewed.

Survey Queue

This is the EXAMPLE FACILITY 1234 Example St. survey queue page.

The signatory physician responsible for overseeing the vaccines, Medical Director, is required to complete a series of forms (surveys) before the VFC application for EXAMPLE FACILITY can be reviewed. The forms serve two purposes: 1. Ensure the signatory provider (Medical Director) knows the requirements. 2. Ensure the facility is able to meet each requirement. Copies of your submitted forms will be emailed to you separately once Bureau of Immunization Services (BIS) staff have verified the forms have been completed. Please note that this email *does not* serve as approval of your application. It is for informational purposes only.

📢 You have completed form 2 of 6.

Status Home Page (continued)

Status	Survey Title
✓ Completed	Provider Agreement
Begin survey	Arizona Vaccines for Children (VFC) Refrigerator and Freezer Verification Form
Begin survey	Arizona Vaccines for Children (VFC) Program Provider Profile
Begin survey	Arizona Vaccines for Children (VFC) Program Prescribing Profile
Begin survey	ASIS Users - #1

❖ Click **Begin survey** to begin Form 3 - Refrigerator and Freezer Verification Form.

Form #3 of 6 - Refrigerator and Freezer Verification Form

Arizona Vaccines for Children (VFC)
Refrigerator and Freezer Verification Form


VFC PIN #

Please indicate the type of units your office is currently using to store V units in the correct box. The form shall be signed and initialized by M Equivalent (M.D., D.O., NP or FNP).

Facility Name: EXAMPLE FACILITY

1) Stand-alone Refrigerator- no freezer inside
OR
A Commercial Refrigerator Unit

I certify that I have a stand-alone refrigerator.


 [Add signature](#) Initials of the Signatory Physician

Number of Units Number of units

If you do not use this type of unit, add "0" to the number of units
* must provide value

2) Stand-alone Freezer
OR
A Commercial Freezer Unit

I certify that I have a stand-alone freezer.

 [Add signature](#) Initials of the Signatory Physician

Number of Units Number of units

If you do not use this type of unit, add "0" to the Number of Units
* must provide value

⚠ Form #3 must be signed and initialed by the individual (M.D., D.O., NP, or FNP) who has primary responsibility for making decisions about your practice and its operations.

❖ Click the **Add signature** link to certify the information entered.

❖ A new window will pop up to enter your initials.

⚠ You must provide a value for **Number of units**. If you do not use this type of unit, put "0" as the number of units.

Form #3 of 6 - Refrigerator and Freezer Verification (continued)

3) Regular Household Refrigerator
With 2 separate outside doors and 2
separate temperature controls

I certify that I have a regular household refrigerator.

 [Add signature](#)

Initials of the Signatory Physician

Number of Units

Number of units

If you do not use this type of unit, add "0" to the Number of Units

- ❖ Click the **Add signature** link to certify the information entered.
- ❖ A new window will pop up to enter your initials.



You must provide a value for **Number of units**. If you do not use this type of unit, input "0" as the number of units.

Vaccine Statement

In addition to the above-stated responses, please answer the following statements to verify that your facility is able to meet the following requirements in addition to the VFC Storage and Handling requirements as outlined in the [Arizona VFC Program Operations Guide](#).

- ❖ Select **Yes or No** for each statement.

I have a continuous temperature monitoring device (data logger) in each of my storage units

☐ Yes ☐ No

* must provide value

[reset](#)

The freezer maintains a temperature of +5°F (-15°C) to -58°F (-50°C)

☐ Yes ☐ No

* must provide value

[reset](#)

Does this site store VFC vaccine in a dorm style or bar style refrigerator?

☐ Yes ☐ No

* must provide value

[reset](#)

I certify that the above-initialed unit(s) will be used to store VFC vaccine. I will adhere to all VFC Storage and Handling and temperature reporting requirements as outlined in the [Arizona VFC Program Operations Guide](#).

 [Add signature](#)

06-18-20

Signature of **Medical Director**, Medical Director or Equivalent (M.D., D.O., NP or other)

* must provide value

- ❖ Click the **Add signature** link.
- ❖ A new window will pop up to enter your signature.

You're not finished yet!

Click the button below to go to the next form.

[Go to the Next Form](#)

[Save & Return Later](#)

- ❖ Click **Go to the Next Form**, if ready to continue to complete the next survey form.
- ❖ Click **Save & Return Later**, to save and continue later.

Status Home Page

⚠️ *You're not finished yet.* The next required form is below. Your submission will not be reviewed until all forms are complete.

You have completed form **3 of 6**. You are required to complete *all* of the survey forms or your submission will not be reviewed.



You have completed form **3 of 6**.

☰ Survey Queue

This is the EXAMPLE FACILITY 1234 Example St. survey queue page.

The signatory physician responsible for overseeing the vaccines, Medical Director, is required to complete a series of forms (surveys) before the VFC application for EXAMPLE FACILITY can be reviewed. The forms serve two purposes: 1. Ensure the signatory provider (Medical Director) knows the requirements. 2. Ensure the facility is able to meet each requirement. Copies of your submitted forms will be emailed to you separately once Bureau of Immunization Services (BIS) staff have verified the forms have been completed. Please note that this email *does not* serve as approval of your application. It is for informational purposes only.

Please click on the "[Begin Survey](#)" button below to complete the next form.

Status	Survey Title
✔️ Completed	Provider Agreement
✔️ Completed	Arizona Vaccines for Children (VFC) Refrigerator and Freezer Verification Form
Begin survey	Arizona Vaccines for Children (VFC) Program Provider Profile Form
Begin survey	Arizona Vaccines for Children (VFC) Program Prescribing Providers - #1
Begin survey	ASIIS Users - #1

❖ Click ***Begin survey*** to start Form 4 – Program Provider Profile Form.


Form #4 of 6 - Program Provider Profile Form

Arizona Vaccines for Children (VFC) Program

Provider Profile Form

This is form 4 of 6

All health care providers participating in the Vaccines for Children (VFC) program must complete this form annually or more frequently if the number of children served changes or the status of the facility changes during the calendar year.

Date: 06-18-2024  M-D-Y



This information will automatically populate from the information entered on the first form.

FACILITY INFORMATION

Provider's Name: Medical Director

Facility Name: EXAMPLE FACILITY

VFC Contact: Vaccine Coordinator

Email: coordinator@email.com

Telephone: (602) 987-6543

Fax

The vaccines must be shipped to the location where they will be administered.

Facility/Shipping Street Address:

1234 Example St.

City: Phoenix

State: AZ

Zip: 54321

Mailing Address or PO Box:

1234 Example St.

City: Phoenix

State: AZ



Provider must be open a minimum of 4 consecutive hours on a day other than Monday to receive vaccines.





VFC providers must be open a minimum of 4 consecutive hours on a day other than Monday to receive vaccines.

Select the days and times the facility is able to receive vaccines.

Example

	Time Open	Time Closed		Time Reopen	Time Closed
If the facility is closed for lunch	8:00	12:00	and	13:00	17:00
If the facility is NOT closed for lunch	8:00	17:00	and	leave blank	leave blank

Click the days the facility is open

open	Time Open	Time Closed	
<input checked="" type="checkbox"/> Monday	<input type="text"/>  H:M	<input type="text"/>  H:M	and
<input checked="" type="checkbox"/> Tuesday	13:30  H:M	<input type="text"/>  H:M	and
<input type="checkbox"/> Wednesday	<div> <div>Choose Time</div> <div>Time 13:30</div> <div>Hour <input type="text"/></div> <div>Minute <input type="text"/></div> <div>Now Done</div> </div>		and
<input type="checkbox"/> Thursday			and
<input type="checkbox"/> Friday			and

- ❖ Click the box next to each day the facility can receive vaccines.
- ❖ Time boxes will appear to enter the times the facility is open/closed.
- ❖ Type in the time or click the clock icon to select a time.
 - Time is listed in military 24-hour time.

Form #4 of 6 -Provider Profile Form (continued)

FACILITY TYPE

Facility Type:

- ☐ Private Facility (privately funded entity; non-governmental)
- ☐ Public Facility (publicly funded or governmental entity)
- ☐ Combination (funded with public and private funds)

❖ Click a circle to select the **Facility Type**.

*Please select only **ONE** provider type that best describes your facility.*

- ☐ Behavioral Health Clinic
- ☐ Birthing Hospital or Birthing Center
- ☐ Community Vaccinator
- ☐ Correctional Facility
- ☐ Family Planning Clinic (non-health department)
- ☐ Federally Qualified Health Center
- ☐ Hospital
- ☐ Indian Health Service, Tribal or Urban Clinic
- ☐ Juvenile Detention Center
- ☐ Migrant Health Center
- ☐ Mobile Provider
- ☐ Pharmacy
- ☐ Private Practice (e.g. family practice, pediatric, primary care)
- ☐ Private Practice (e.g. family practice, pediatric, primary care) as agent for FQHC/RHC-deputized
- ☐ Public Health Clinic (state/local)
- ☐ Public Health Clinic (state/local) as agent for FQHC/RHC-deputized
- ☐ Refugee Health Clinic
- ☐ Residential/Congregate Care Facility
- ☐ Retail Health Clinic
- ☐ Rural Health Clinic
- ☐ School Health Clinic
- ☐ STD/HIV Clinic
- ☐ Student Health Services
- ☐ Teen Health Center
- ☐ Immediate Care Center
- ☐ Woman, Infants and Children (WIC) Clinic
- ☐ Other

- ❖ A list of provider types will appear.
- ❖ Click the box next to the **ONE** provider type that best describes your facility.



For more information about the provider types see the [Helpful Definitions](#) at the end of this guide.

Please indicate the specialty of the provider practice. (Select all that apply)

- ☐ Community Health Center
- ☐ Family/General
- ☐ Pediatrics
- ☐ Other

- ❖ Click the box(es) next to the provider practice specialties that apply.

Form #4 of 6 -Provider Profile Form (continued)


PROVIDER POPULATION

*You **must** provide an estimate of the patients that this location will see in a year that are VFC or non-VFC eligible.*

Provider Population is based on patients seen during the previous 12 months. Report the number of children who received vaccinations at your facility, by age group. Only count a child once based on a single visit, regardless of the number of visits made. The following table documents how many children are eligible by category, and how many received non-VFC vaccine. If you need assistance, please call 1-800-364-3642.

VFC Vaccine Eligibility Categories	# of children who received VFC Vaccine	
	< 1 Year	1-6
Enrolled in Medicaid (AHCCCS)	20	10
No Health Insurance (Uninsured)	5	7
American Indian/Alaska Native	0	0
Total VFC:	25	17

Non-VFC Vaccine Eligibility Categories	# of children who received non-VFC vaccine	
	< 1 Year	1-6
Insured (private pay/health insurance covers vaccines)		
Enrolled in CHIP (KidsCare) ¹		
Underinsured in non-deputized facility ²		
Total Non-VFC:		


 **ERROR:** Provide a patient population estimate in e


Total Patients (must equal sum of Total VFC + Total Non-VFC)	25	17
---	-----------	-----------


¹ CHIP (KidsCare) - Children enrolled in the state Children's Health Insurance Program (CHIP). These children are considered insured and are not eligible for vaccines through the VFC program. Each state provides specific guidance on how CHIP vaccine is purchased and administered through participating providers.

² Underinsured - children with health insurance but the coverage does not include all vaccines. When an Underinsured child presents at a non-deputized facility, the provider must determine if the child is covered by health insurance. For the vaccines not covered by health insurance, the underinsured child is referred to a deputized provider office, CHD, FQHC or RHC. The child receives the vaccine from the administered private vaccine stock and charged out-of-pocket.

- ❖ Complete the chart to provide an **estimate** of the patients the location will see in a year that are VFC and/or non-VFC eligible.
- ❖ Enter an amount in the corresponding box. The chart will automatically calculate the totals.

 No field can be left blank. Put 0 if no one is anticipated for that population, but you cannot enter all zeros.

 If you do not know your anticipated numbers enter your **best estimate**.

 Helpful definitions are located below the chart.

Form #4 of 6 - Provider Profile Form (continued)

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

- ☐ ASIIS
- ☐ Benchmarking
- ☐ Billing System
- ☐ Doses Administered
- ☐ Medicaid Claims Data
- ☐ Other
- ☐ Provider Encounter Data

* must provide value

You're not finished yet!
Click the button below to go to the next form, then

[Go to the Next Form](#)

❖ Click the box next to the **Data Type** that was used to determine the provider population. Choose as many as apply.

❖ Click **Go to the Next Form** to return to the status page and complete the next form.

Status Home Page

You have completed form 4 of 6. You are required to complete *all* of the survey forms or your submission will not be reviewed.

You have completed form 4 of 6.

Survey Queue
This is the EXAMPLE FACILITY 1234 Example St. survey queue page.

The signatory physician responsible for overseeing the vaccines, Medical Director, is required to complete a series of forms (surveys) before the VFC application for EXAMPLE FACILITY can be reviewed. The forms serve two purposes: 1. Ensure the signatory provider (Medical Director) knows the requirements. 2. Ensure the facility is able to meet each requirement. Copies of your submitted forms will be emailed to you separately once Bureau of Immunization Services (BIZS) staff have verified the forms have been completed. Please note that this email *does not* serve as approval of your application. It is for informational purposes only.

Please click on the "Begin Survey" button below to complete the next form.

Status	Survey Title
✔ Completed	Provider Agreement
✔ Completed	Arizona Vaccines for Children (VFC) Refrigerator and Freezer Verification Form
✔ Completed	Arizona Vaccines for Children (VFC) Program Provider Profile Form
Begin survey	Arizona Vaccines for Children (VFC) Program Prescribing Providers - #1
Begin survey	ASIIS Users - #1

❖ Click **Begin survey** to begin Form 5 – Prescribing Providers.

Form #5 of 6 - Program Prescribing Providers

Arizona Vaccines for Children (VFC) Program

Prescribing Providers

You're not finished yet! *This is form 5 of 6*

PROVIDERS PRACTICING AT EXAMPLE FACILITY - 1234 Example St.

Instructions: You are required list all licensed health care providers (MD, DO, NP, PA, Pharmacist) who have prescribing authority. This survey form can be submitted repeatedly for multiple healthcare providers at this location.

Once all the licensed health care providers who have prescribing authority have been entered, click the **Go to the Next Form** button at the end of the page.

Provider Name
* must provide value

Title
* must provide value

Specialty:
* must provide value

License No.
* must provide value


Medicaid or NPI No.
* must provide value

EIN (optional)

Click on the "Go to the Next Form" button below when you have entered all the health care providers at your facility who have prescribing authority.

This is form 5 of 6

Submit and

 Click here to add another Prescribing Provider

- or -

Go to the Next Form

❖ Complete the form for each licensed health care provider (MD, DO, NP, PA, Pharmacist) at your facility who has prescribing authority.

- ❖ Click **Add another Prescribing Provider**, if you have additional health care providers who have prescribing authority.
- ❖ Click **Go to the Next Form**, to return to the status page and complete the next survey form.

Status Home Page

You have completed form **5 of 6**. You are required to complete *all* of the survey forms or your submission will not be reviewed.

Survey Queue

This is the EXAMPLE FACILITY 1234 Example St. survey queue page.

The signatory physician responsible for overseeing the vaccines, Medical Director, is required to complete a series of forms (surveys) before the VFC application for EXAMPLE FACILITY can be reviewed. The forms serve two purposes: 1. Ensure the signatory provider (Medical Director) knows the requirements. 2. Ensure the facility is able to meet each requirement. Copies of your submitted forms will be emailed to you separately once Bureau of Immunization Services (BIS) staff have verified the forms have been completed. Please note that this email *does not* serve as approval of your application. It is for informational purposes only.

Please click on the "Begin Survey" button below to complete the next form.

Status	Survey Title
✓ Completed	Provider Agreement
✓ Completed	Arizona Vaccines for Children (VFC) Refrigerator and Freezer
✓ Completed	Arizona Vaccines for Children (VFC) Program Provider Profile Form
✓ Completed	Arizona Vaccines for Children (VFC) Program Prescribing Providers - #1: Example Provider
	+ Click here to add another Prescribing Provider
Begin survey	ASIIS Users - #1



You have completed form **5 of 6**.

❖ Click ***Begin survey*** to begin Form 6 – ASIIS Users.

Form #6 of 6 – ASIIS Users

ASIIS Users

Add/Remove ASIIS Users

Please list the full name, email and select a user access level for additional staff members with access level changes or for removal.

Please note: The Primary Coordinator: Vaccine Coordinator and Back-up Coordinator Access by default.

- **Access Level 0 - Remove User**
- **Access Level 1 - View Only Permissions** - can view patients and immunization records
- **Access Level 2 - Edit Permissions** - can view, add and make changes to patient records
- **Coordinator Access - Additional Back-up Coordinator** - can view, add and make changes to patient records; can process vaccine orders and reconciliation.

Please Note: The Primary and Back-up coordinators added on Form 1 will be assigned Coordinator Access by default.

Do you need to add/remove any more ASIIS users?

* must provide value



The Primary and Back-up coordinators added on Form 1 will be assigned Coordinator Access by default.

- ❖ Click **Yes** to add/remove ASIIS user access.
- ❖ Click **No** if no changes are needed.

Yes

No

reset

Form #6 of 6 – ASIIS Users (continued)

Please Note: The Primary and Back-up coordinators added on Form 1 will be assigned Coordinator Access by default.

Do you need to add/remove any more ASIIS users?

* must provide value

Access Level 0 - Remove User

Access Level 1 - View Only Permissions

Access Level 2 - Edit Permissions

Coordinator Access- Use for Additional Back-up Coordinator

* must provide value

Access level 1

Access level 2

Coordinator access

reset

First Name

* must provide value

First Name

Last Name

* must provide value

Last Name

Email

* must provide value

Email

40 characters remaining

All Users shall electronically accept the terms of the Pledge to Protect
ASIIS is a computer based immunization registry and tracking system for the Arizona Department of Health Services and its partners. It is intended to aid health care professionals in tracking immunization status according to A.R.S § 36-135, R9-6-707, and R9-6-708. Clicking on this button indicates that you are only available to authorized users and the Arizona Department of Health Services and agree to adhere to all Confidential Information available on the ASIIS Main page.

Click the **submit** button when you are done requesting

❖ Select the access level and enter the information of the individual that needs ASIIS access added or removed.

- ❖ Click the **add/remove another ASIIS user** button to save your entry and add/remove another user.
- ❖ Click **Submit** when you are done requesting ASIIS access for your staff members.

This is form **6** of **6**

Submit and

↻ Click here to add/remove another ASIIS user

- or -

Submit

Status Home Page

Once all forms have been completed, the AIPO will review your submission. You will know when all forms have been completed because the word "Completed" will be in green next to each form below.

Copies of your submitted forms will be emailed to you separately once BIZS staff have verified the forms have been completed. Please note that this email does not serve as approval of your submission.



You have completed form 6 of 6.

Survey Queue

This is the EXAMPLE FACILITY 1234 Example St. survey queue page.

The signatory physician responsible for overseeing the vaccines, Medical Director, is required to complete a series of forms (surveys) before the VFC application for EXAMPLE FACILITY can be submitted. Once the Medical Director has completed the forms, the signatory provider (Medical Director) knows the requirements. Your submitted forms will be emailed to you separately once BIZS staff have verified the forms have been completed. Please note that this email *does not* serve as approval of your submission.

Please click on the "[Begin Survey](#)" button below to complete the survey.

Status	Survey Title
✔ Completed	Provider Agreement
✔ Completed	Arizona Vaccines for Children (VFC) Refrigerator and Freezer Verification Form
✔ Completed	Arizona Vaccines for Children (VFC) Program Provider Profile Form
✔ Completed	Arizona Vaccines for Children (VFC) Program Prescribing Providers - #1: Example Provider + Click here to add another Prescribing Provider
✔ Completed	ASIIS Users - #1: Example User
✔ Completed	ASIIS Users - #2 + Click here to add/remove another ASIIS user

- ❖ Once all forms have been completed, the BIZS will review your submission.
- ❖ Copies of your submitted forms will be emailed to you once verified complete. This is not an approval; it is for informational purposes only.

PROVIDER ENROLLMENT CHECKLIST

Use the following checklist to help track your progress for completing your enrollment.

Status	Provider Agreement Item
	Practice Details/Facility Details
	Practice Name
	Facility address
	Vaccine delivery address
	Mailing address
	Contact details - names, email addresses, telephone and fax numbers
	Primary vaccine coordinator (required)
	Back-up vaccine coordinator(s) (required)
	Signatory Physician (required)
	Office Manager (If applicable)
	Certificates for Vaccine Coordinator(s) completed training (annual requirement)
	Primary vaccine coordinator (required)
	Back-up vaccine coordinators (required)
	All vaccine staff (strongly recommended)
	Physician/Vaccinator details - Provide the name, specialty, Arizona State Medical License Number, and National Provider ID (NPI) for each physician prescribing vaccines in your practice.
	Medical License Numbers (required)
	National Provider IDs (NPI) (required)
	Shipping Days and Times —Provide the days of the week and core business hours that staff is available to receive vaccine shipments. Must be open for a minimum of four consecutive hours on a day other than Monday to receive vaccines.
	Practice/Provider Profile - Provide information about the <u>estimated number</u> of children who will receive immunization at your practice during the calendar year (January 1 through December 31 of the given year) by age group, insurance type, and demographics.
	Cold Storage Unit details —Provide information about the storage units you will use to store VFC vaccines and the data loggers you will use to monitor temperatures in those storage units and answer the following questions
	I have a continuous temperature monitoring device (data logger) in each of my storage units
	The freezer maintains a temperature of +5°F (-15°C) to -58°F (-50°C)
	Does this site store VFC vaccine in a dorm-style or bar-style refrigerator?

The following documents will be gathered during/after the New Provider In-Service (NPIS)

	Completed and signed Vaccine Accountability and Management Plan
	Valid data logger calibration certificates for all units storing VFC vaccines
	Valid data logger calibration certificates for the back-up data logger

HELPFUL DEFINITIONS

- **Behavioral Health Clinic** - Locations that provide counseling, behavioral therapy, medication, case management, and other types of services to persons with behavioral health disorders. This provider type is used for behavioral health treatment centers where on-site vaccination services are provided.
- **Birthing Hospital or Birthing Center** - Birthing Hospital or Birthing Center where on-site vaccination services are provided.
- **Community Vaccinator** - Community-wide vaccinators that are external to health departments and conduct vaccination clinics in satellite, temporary, or offsite locations exclusively.
- **Correctional Facility** - Juvenile correctional facilities as well as adult correctional facilities where juveniles are confined, and onsite vaccination services are provided. Unlike juvenile detention centers, correctional facilities are long term in nature; youths are confined in secure correctional facilities for periods generally ranging from a few months to a year or more.
- **Family Planning Clinic (non-health department)** - Clinics that provide contraceptive services for clients who want to prevent pregnancy and space births, pregnancy testing and counseling, assistance to achieve pregnancy, basic infertility services, STD services (including HIV/AIDS), and other preconception health services (e.g., screening for obesity, smoking, and/or mental health). This provider type is used for family planning clinics where vaccination services are provided.
 - Non-health department clinics that offer only STD/HIV screening and treatment services should be categorized as “STD/HIV Clinic (non-health department).”
- **Federally Qualified Health Center** - Community-based health care providers that offer primary care services in underserved areas and meet the criteria for “Federally Qualified Health Center (FQHC)” certification as set by the Centers for Medicare and Medicaid Services (CMS) (Section 1861(aa)(4)(B) and section 1905(l)(2)(B) of the Social Security Act). FQHCs include HRSA Health Center Program award recipients and HRSA Health Center Program look-alikes, which are

health centers that meet Health Center Program requirements but do not receive federal award funding.

- Certain tribal organizations are also FQHCs. However, for tribal or urban Indian health clinics enrolled as FQHCs, use the “Indian Health Service, Tribal, or Urban Clinic” designation. The FQHC provider type includes any satellite, temporary, or off-site locations where the provider of record (i.e., FQHC personnel) is administering vaccine.
- **Hospital** - All hospitals, except for birthing hospitals, where on-site vaccination services are provided.
 - For birthing hospitals, use the “Birthing Hospital or Birthing Center” designation.
- **Indian Health Service, Tribal, or Urban Clinic** - Indian Health Service (IHS), Tribal, or Urban Indian Health Program facilities that provide vaccination services. Urban Indian Health Centers are also designated Federally Qualified Health Centers and provide comprehensive primary care and related services to American Indians and Alaska Natives. Alaska Village Clinics should be included in this provider type.
- **Juvenile Detention Center** - Juvenile detention centers where on-site vaccination services are provided. Juvenile detention is defined as the temporary and safe custody of juveniles who are accused of conduct subject to the jurisdiction of the court who require a restricted environment for their own or the community’s protection while pending legal action.
- **Migrant Health Center** - Centers that provide health services, including on-site vaccination services, to migratory and seasonal agricultural workers and their families.
- **Mobile Provider** - Providers who exclusively store and administer vaccines out of a mobile facility. This designation should NOT be used for providers who have a mobile unit associated with their facility, but the unit is not the primary site for vaccine administration.
- **Pharmacy** - Stand-alone retail pharmacies (e.g., CVS, Duane Reade, Walgreens) or retail pharmacies within a hospital or health system where on-site vaccination

services are provided. This category also includes retail pharmacies that conduct community vaccination clinics at offsite or mobile locations.

- **Private Practice** (e.g., family practice, pediatric, primary care) - Private practice locations, including solo, group, or HMO practitioners, where vaccination services are provided.
 - Includes any temporary, mobile, off-site, or satellite locations where the provider of record (i.e., provider location personnel) is administering vaccine.
- **Private Practice** (e.g., family practice, pediatric, primary care) **as agent for FQHC/RHC-deputized** - A deputized provider has been delegated by a Federally Qualified Health Center (FQHC) or a Rural Health Clinic (RHC) as an agent to vaccinate underinsured children. This provider type is used for deputized private practices, including solo, group, or HMO practitioners, that provide vaccination services.
 - Includes any temporary, mobile, off-site, or satellite locations where the provider of record (i.e., deputized private practice personnel) is administering a vaccine.
- **Public Health Department Clinic** (state/local) - State or local public health department clinics that provide vaccination services. This category includes public health department-run STD/HIV clinics, family planning clinics, and teen health centers. NOTE: Includes any temporary, mobile, off-site, or satellite locations where the provider of record (i.e., public health clinic personnel) is administering vaccine.
- **Public Health Department Clinic** (state/local) **as agent for FQHC/RHC-deputized** - A deputized provider has been delegated by a Federally Qualified Health Center (FQHC) or a Rural Health Clinic (RHC) as an agent to vaccinate underinsured children. This provider type is used for deputized state or local public health department clinics that provide vaccination services. NOTE: Includes any temporary, mobile, off-site, or satellite locations where the provider of record (i.e., deputized public health clinic personnel) is administering vaccine.
- **Refugee Health Clinic**- Clinics that are designated to improve the health and monitor medical conditions of refugees who have relocated to the United States.

This provider type is used for refugee health clinics that provide vaccination services. NOTE: If vaccination services are provided in a location that is co-located in a physical facility with a refugee health clinic but are not administered by refugee health staff, select the category of the provider with oversight of vaccination services.

- **Residential/Congregate Care Facility** - Out-of-home settings, including group homes, childcare institutions, and congregate foster care facilities, where onsite vaccination services are provided.
 - If children in these settings receive vaccinations from a mobile provider or community vaccinator, then that provider type should be used.
- **Retail Health Clinic** - Health clinics located within grocery, drug, or retail stores that provide onsite vaccination services. Retail health clinics generally provide a focused range of protocol-driven healthcare services, such as the treatment of minor illnesses or injuries and vaccination services (e.g., Minute Clinic, Take Care Clinic).
- **Rural Health Clinic** - Clinics located in a non-urbanized Health Professional Shortage Area, Medically Underserved Area, or governor-designated and secretary-certified shortage area. This provider type is used for rural health clinics that provide vaccination services
- **School-Based Clinic** (permanent clinic location) - Permanent school-based clinics that provide vaccination services through 12th grade.
 - For non-permanent school-based clinics, use the “Community Vaccinator” designation. The School-Based Clinic (permanent clinic location) provider type includes any temporary, mobile, off-site, or satellite locations where the provider of record (i.e., school-based clinic personnel) is administering vaccine.
- **Specialty Provider** - For purposes of the VFC program, “specialty providers” are defined as providers who offer limited care in a specialized environment or for a specific age group within the general population of children aged 0–18 years (e.g., birthing hospitals, birthing centers). Awardees have the option to allow specialty providers to administer only vaccines recommended for the specific populations the providers serve.

- **STD/HIV Clinic** (non-health department) - Clinics that provide timely STD/HIV diagnosis, testing with on-site treatment, and partner services. This provider type is used for STD/HIV clinics NOT located within a health department where on-site vaccination services are provided.
 - This category should be used by non-HD clinics that exclusively offer STD/HIV screening and treatment services.
- **Student Health Services** - Permanent school-based clinics that provide vaccination services for college/university students (e.g., Job Corps).
- **Teen Health Center (non-health department)** - Teen health centers that are NOT public health department-sponsored and provide on-site vaccination services.
- **Urgent/Immediate Care Center** - Locations that provide immediate medical outpatient care for the treatment of acute and chronic illness and injury. This provider type should be used for urgent care centers or walk-in clinics where on-site vaccination services are provided.
- **Women, Infants, and Children (WIC) Clinic** - Locations that serve low-income pregnant, postpartum, and breastfeeding women, infants, and children up to age 5 who are at nutritional risk by providing nutritious foods to supplement diets, information on healthy eating including breastfeeding promotion and support, and referrals to health care. This provider type is used for WIC clinics that also provide vaccination services.
 - If vaccination services are provided in a location that is co-located in a physical facility with a WIC clinic but are not administered by WIC staff, select the category of the provider with oversight of vaccination services.
- **Other** - Any provider type not captured in one of the other provider type options (e.g., CVS Minute Clinic or Walgreens Take-Care Clinic).

FREQUENTLY ASKED QUESTIONS

Question 1. What is the NPI number?

The National Provider Identifier (NPI) is a unique 10-digit identification number issued to health care providers in the United States by the Centers for Medicare and Medicaid Services (CMS). The NPI has replaced the unique provider identification number (UPIN) as the required identifier for Medicare services and is used by other payers, including commercial healthcare insurers.

The NPI is one of the steps that CMS is using to improve electronic transactions for health care. National standards for electronic health care transactions encourage electronic commerce in the healthcare industry and simplify the processes involved to reduce the administrative burdens on health care providers. With national standards and identifiers in place for electronic claims and other transactions, health care providers can submit transactions to any health plan in the United States. Health plans can send standard transactions such as remittance advice and referral authorizations to health care providers. These national standards make electronic data interchange a viable and preferable alternative to paper processing for health care providers and health plans alike.

Question 2. What equipment do I need to purchase to enroll in the Arizona VFC program?

Providers can use the following resources to assist with identifying required equipment:

- [Storage Unit Requirements \(Refrigerators & Freezers\)](#)
- [Digital data Logger Requirements](#)

Question 3. Do other trainings substitute for the “You Call the Shots” online training?

The CDC “You Call the Shots” training (modules Vaccines for Children or Vaccine Storage and Handling) is one of the methods of training. The other training option is [AIPO Train](#) - Arizona Vaccines for Children Training. For any issues with AIPO Train please contact aipotrain@azdhs.gov.

Question 4. Do all providers listed in the Provider Agreement need to complete annual training?

The primary and backup vaccine coordinators are required to complete an annual training. We strongly recommend that all staff and providers in the clinic who work with or manage any aspect of immunizations also take the training.

Question 5. Does the 2-day Epidemiology and Prevention of Vaccine-Preventable Diseases “Pink Book” course count for training of the vaccine coordinators?

The 2-day “Pink Book” course does not count as training for vaccine coordinators.

Question 6. What training is acceptable for the VFC Coordinators?

The acceptable training requirements are located in the [Are You a New Primary/Backup VFC Vaccine Coordinator? Job aid.](#)

Question 7. How long do we keep the training certificates?

Records related to vaccine management training must be kept for six (6) years, either on-site or off-site. If kept off-site, they must be made available within 2 hours if requested. Electronic records are acceptable.

Question 8. Can you please explain more about who can be the signatory for the Provider Agreement?

A provider licensed in the state of Arizona to prescribe vaccines (M.D., D.O., NP or FNP), who is responsible for making decisions about the clinic and its operations. The signatory provider must have authority to ensure that the practice/clinic/facility and all providers listed on the agreement adhere to the requirements of the program, must be an active provider within that facility, and must have a valid medical license to administer vaccines.

Question 9. Can a P.A. sign as the medical director?

No, a P.A. cannot sign as the medical director. Only an M.D., D.O., NP or FNP can sign. The signing physician is responsible for making sure their practice stays in compliance with the VFC program.

Question 10. Can you clarify the American Indian/Alaska Native status?

Any patient who identifies as American Indian or Alaska Native should be counted towards your American Indian/Alaska Native VFC eligible population.

Question 11. Can the primary and backup vaccine coordinators be the primary and/or backup coordinators at other locations?

No, there needs to be a unique primary and backup coordinator designated for each site and they must be located on-site.

Question 12. My office is small; why do I need a backup coordinator?

All VFC providers must have a primary and backup coordinator. The coordinators can be anyone in the office. The primary and backup coordinators are required to know the same policies and procedures of the VFC Program, and both must complete the required annual training. Please see Module 2 in the [VFC Operations Guide](#) for specific staff requirements.

Question 13. What if my office does not have a computer or only 1 computer used by the physician?

If necessary, please make the appropriate arrangements to make sure you set up time for computer access.

Question 14. How will I be notified once my re-enrollment is complete?

The primary vaccine coordinator from your VFC pin will receive an email once your re-enrollment is approved and completed.

Question 15. Who do I contact for additional assistance or questions?

Contact ArizonaVFC@azdhs.gov.