TEXAS VACCINES FOR CHILDREN PROGRAM: PROVIDER ENROLLMENT

CHIP

This record is to be submitted to the Texas Department of Health and must be updated in accordance with State policy.

Name of Facility or Clinic: ____

Provider Name: ____
(Last Name) (First Name) (MI) (Title)

Contact: ____
(Last Name) (First Name) (MI) (Title)

Mailing Address: ____
(P.O. Box or Street Address) (City) (Zip)

Address for Vaccine Delivery: ____

Telephone Number: ___________________________________ Fax Number: _______________________________

Provider Identification Number (Medical License Number): ____
____

In order to participate in the Texas Vaccines for Children Program and/or to receive federally and state-supplied vaccines provided to me at no cost, I, on behalf of myself and any and all practitioners associated with this medical office, group practice, health department, community/migrant/rural health clinic, or other organization of which I am the physician-in-chief or equivalent, agree to the following:

1. Before administering vaccines obtained through the Texas Vaccines for Children Program, my office will determine VFC eligibility. The Patient Eligibility Screening Form will be provided to the parent or guardian to declare each child's eligibility.

2. My office will maintain records of the parent/guardian/authorized representative=s responses on the Patient Eligibility Screening Form for a period of 3 years, unless State requirements call for a longer duration. If requested, my office will make such records available to the Texas Department of Health (TDH), the local health department/authority or the U.S. Department of Health and Human Services.

3. My office will comply with the appropriate immunization schedule, dosage, and contraindications, as established by the Advisory Committee on Immunization Practices, unless (a) in making a medical judgment in accordance with accepted medical practice, my office deems such compliance to be medically inappropriate, or (b) the particular requirement is not in compliance with Texas Law, including laws relating to religious and medical exemptions.

4. My office will provide Vaccine Information Statements to the responsible adult, parent, or guardian and maintain records in accordance with the National Childhood Vaccine Injury Act. (Signatures are required for the Vaccine Information Statements for each vaccine type administered.)

5. My office will not charge for vaccines supplied by TDH and administered to a child who is eligible for the Texas Vaccines for Children Program.

6. My office may charge a vaccine administration fee. My office will not impose a charge for the administration of the vaccine in any amount higher than the maximum fee established by TDH. Medicaid patients cannot be charged for the vaccine, administration of vaccine, or an office visit associated with Medicaid services.

7. My office will not deny administration of a Texas Vaccines for Children Program vaccine to a child because of the inability of the child=s parent or guardian/individual of record to pay an administrative fee.

8. My office will comply with the State=s requirements for ordering vaccine and other requirements as described by TDH.

9. My office will make certain that parents or guardians have the opportunity to approve or decline that their child's immunization information be included in the statewide immunization registry.

10. My office or the State may terminate this agreement at any time for personal reasons or failure to comply with these requirements.

____ ____
(Provider Signature) (Date)

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Public and private TVFC providers must complete the front and back of this form *annually*, and/or when the clinic type changes (for example: a private provider becomes an agent of a federally Qualified Health Center).

Date: A. Name of Facility of Clinic:

B. Provider Name (Physician-in–Charge)

C. Vaccine Shipping Address:
(Street Address)   (City)   (Zip)   (County)

D. Phone Number (   )   -

E. Is your facility a Federally Qualified Health Center (Migrant or Rural Health clinic)? (circle one) YES NO

F. Type of Clinic: (check one)

Public Health Department/District	Private Hospital
Public Hospital	Private practice (Individual or Group)
Other Public Clinic	Other Private Clinic

G. PATIENT PROFILE:

	<1 year old	1-6 years old	7-18 years old	19+ years old	Total
TOTAL PATIENTS: Please enter the number of children, by age group who will receive vaccinations at your clinic in Calendar Year 2000.					

H. Categories of Children Eligible for the Texas vaccines for Children Program:
Of the total numbers of children entered in Section G, please enter the number of children for each of the following categories by age group (the numbers below added together should equal the entries in Category G above):

NUMBER OF CHILDREN IN EACH CATEGORY	<1 year old	1-6 years old	7-18 years old	19+ years old	Total
a. Number enrolled in Medicaid					
b. Uninsured (Note: Children enrolled in Health Maintenance Organization are considered insured.)					
c. Number of American Indians					
d. Number of Alaskan Natives					
e. Underinsured					
f. Children who do not meet any of the above criteria, but still receive immunizations at public health clinics					
g. Children who receive benefits from the Childrens Health Insurance Plan (CHIP)					

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Purpose: To determine eligibility and the source of funds for the Texas Department of Health to be reimbursed for vaccines.

A record must be kept in the office of the health care provider that reflects the status of all children 18 years of age or younger, who receive immunization through the Texas Vaccines for Children Program. The record may be completed by the parent, guardian, or individual of record, or by the health care provider. This same record may be used for all subsequent visits as long as the child's eligibility status has not changed. While verification of responses is not required, it is necessary to retain this or a similar record for each child receiving vaccines.

Date of Screening: ______________________

Child's Name: ____
Last Name First Name MI

Child's Date of Birth: ________/________/

Parent/Guardian/
Individual of Record: ____
Last Name First Name MI

Provider's Name: ____

The above named child qualifies for vaccines through the Texas Vaccines for Children Program because he/she (check 1st category that applies, check only one):

9 (a) is a patient who receives benefits from the Children's Health Insurance Plan (CHIP)

9 (b) enrolled in Medicaid or

9 (c) does not have health insurance or

9 (d) is an American Indian or

9 (e) is an Alaskan Native or

9 (f) is underinsured (has health insurance that **Does Not** pay for vaccines) & routinely referred to a Federal Qualified Health Center or Rural Health Clinic for immunizations or

9 (g) is underinsured (has health insurance that **Does Not** pay for vaccines) & routinely referred to a facility that is not a Federally Qualified Health Center or Rural Health Clinic for immunizations or

9 (h) is a patient who is served by any type of public health clinic and does not meet any of the above criteria

"I have been given a copy of the Vaccine Information Statement for each vaccine that will be received today. I have read this information or someone has told me what it says. I know the benefits and risks of the vaccine. I also know the risks of the disease the vaccine prevents. I ask that the vaccine or vaccines checked be given to me or to the child for whom I can consent. I agree that the information on this record may be given to school, officials, public health officials, authorized governmental agencies, and other health care staff."

____
(Parent/Guardian signature)

Please list all providers within the practice participating in the TVFC

CHIP

LAST NAME	FIRST NAME	MIDDLE INITIAL	TITLE	MEDICAL LICENSE NUMBER	MEDICAID PROVIDER NUMBER	SPECIALTY