

# TEXAS VACCINES FOR CHILDREN PROGRAM (TVFC): PROVIDER ENROLLMENT

Initial enrollment\*     Re-enrollment     Provider PIN Number \_\_\_\_\_

(\*Contact the Health Services Region [HSR] in your area to obtain PIN)    Responsible Entity \_\_\_\_\_

Name of Facility, Practice, or Clinic: \_\_\_\_\_

Provider Name (M.D., D.O., N.P., R.Ph., P.A., or C.N.M.\*): \_\_\_\_\_  
(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: \_\_\_\_\_  
(Street Address and Suite Number) (City) (County) (Zip)

Telephone Number: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_    Fax Number: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
(Area Code) (Area Code)

E-mail Address: \_\_\_\_\_

*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, agree to the following:*

- 1) This office/facility will screen patients for TVFC eligibility at all immunization encounters, and administer TVFC-purchased vaccine only to children 18 years of age or younger who meet one or more of the following criteria: (1) Is an American Indian or Alaska Native; (2) is enrolled in Medicaid; (3) has no health insurance; (4) is underinsured: children who have commercial (private) health insurance but the coverage does not include vaccines, children whose insurance covers only selected vaccines (TVFC- eligible for non-covered vaccines only), children whose insurance caps vaccine coverage at a certain amount (once that coverage amount is reached, these children are categorized as underinsured); 5) is a patient who receives benefits from the Children's Health Insurance Plan (CHIP).
- 2) This office/facility will maintain all records related to the TVFC program, including parent/guardian/authorized representative's responses on the Patient Eligibility Screening Form for at least **five** years. If requested, this office/facility will make such records available to the Texas Department of State Health Services (DSHS), the local health department/authority, or the U.S. Department of Health and Human Services.
- 3) This office/facility will comply with the appropriate vaccination 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, this office/facility 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) This office/facility will provide Vaccine Information Statements (VIS) to the responsible adult, parent, or guardian and maintain records in accordance with the National Childhood Vaccine Injury Act which include reporting clinically significant adverse events to the Vaccine Adverse Event Reporting System (VAERS). Signatures are required for informed consent. (The Texas Addendum portion of the VIS may be used to document informed consent.)
- 5) This office/facility will not charge for vaccines supplied by DSHS and administered to a child who is eligible for the TVFC.
- 6) This office/facility may charge a vaccine administration fee to non-Medicaid or non-CHIP TVFC eligible patients not to exceed \$14.85. Medicaid patients cannot be charged for the vaccine, administration of vaccine, or an office visit associated with Medicaid services. For Medicaid patients, this office/facility agrees to accept the reimbursement for immunization administration set by the state Medicaid agency or the contracted Medicaid health plans.
- 7) This office/facility will not deny administration of a TVFC vaccine to a child because of the inability of the child's parent or guardian/individual of record to pay an administrative fee.
- 8) This office/facility will comply with the State's requirements for ordering vaccine and other requirements as described by DSHS, and operate within the TVFC program in a manner intended to avoid fraud and abuse.
- 9) This office/facility or the State may terminate this agreement at any time for failure to comply with these requirements. If the agreement is terminated for any reason this office/facility agrees to properly return any unused vaccine.
- 10) This office/facility will allow DSHS (or its contractors) to conduct on-site visits as required by VFC regulations.

\_\_\_\_\_  
(Signature\*)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Print Name and Title)

\* A licensed Medical Doctor, Doctor of Osteopathy, Nurse Practitioner, Physician Assistant, Registered Pharmacist, or a Certified Nurse Midwife must sign the TVFC Enrollment form.



