

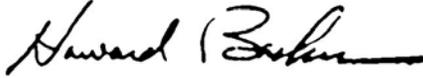


MARK B HORTON, MD, MSPH  
Director

State of California—Health and Human Services Agency  
California Department of Public Health



ARNOLD SCHWARZENEGGER  
Governor

Date: August 9, 2007  
TO: Local Health Officers, Immunization Coordinators  
FROM: Howard Backer, M.D., M.P.H., Chief Immunization Branch   
SUBJECT: Annual Public Sector Vaccines for Children (VFC) Recertification

### Background

The Vaccine for Children (VFC) Program and the Immunization Branch thank you for participating this past year in the VFC Program. We appreciate your efforts to ensure that children in your community are fully immunized. It is a federal requirement that each public and private VFC provider site enrolled in the program renew its certification **annually** for continued participation in the program. This includes private providers, local health departments, nonprofit community health centers, schools, Head Start Centers, colleges and universities, etc. that receives publicly purchased vaccines through VFC.

***To continue as a VFC provider, the physician in charge of the practice will need to complete three forms and return them to us by September 6, 2007.***

### 2007 Recertification Process

This year's recertification process will be slightly different due to the consolidation of public and private providers in the State of California into a centralized ordering system through the VFC Program and the transition to a national vaccine distribution system through McKesson Specialty. Each public and private site will renew recertification using the recertification forms briefly described below. All three recertification forms must be completed for each individual site with an assigned PIN number.

As a result of the Program's transition to a centralized national distribution system, the frequency for the submission of VFC orders is now based on the annual volume of vaccines doses distributed to each individual provider:

- Large Providers receiving over 2000 Doses/Year-Order Monthly
- Medium-Sized Providers receiving 500-2000 Doses/Year)-Order Every Two Months
- Small Providers receiving less than 500 Doses/Year)-Order Quarterly

Information on your practice's assigned frequency for the submission of VFC Orders will be indicated in the enclosed "Report of Doses Distributed vs. Doses Administered". Please ensure that clinic staff responsible for vaccine ordering is aware of your clinic's assigned order frequency. VFC vaccine orders must be submitted following this assigned frequency.

## Forms

### **VFC Provider Enrollment Form (DHS 8500PRI 5/07)**

Several changes have been made on the VFC Provider Enrollment form this year:

- Item 13: VFC Providers agree to purchase a new refrigerator or freezer unit if storage equipment is deemed inappropriate for vaccine storage or unit is not able to maintain appropriate temperatures. Small single-door (dormitory-style or bar-style) combined refrigerator/freezer units are considered inappropriate for vaccine storage.
- Item 6: VFC Providers agree to administer age-appropriate immunizations to patients served in compliance with recommendations established by ACIP.
- Item 11: VFC Providers agree to submit VFC vaccine orders according to the order frequency category identified for their practice.

### **A copy of the VFC Provider Enrollment Form with an original signature is required.**

Please complete the original for us and retain the yellow copy for your file. Fax copies of this form cannot be accepted.

**If you have enrolled in VFC or submitted recertification paperwork to re-activate your VFC account within the past month, you must re-submit a signed copy of the VFC Provider Enrollment Form, due to the outlined changes above.**

### **VFC Provider Profile Form (DHS8499PRI 5/07)**

On this form, please complete the basic information and then provide your best estimate of the number of VFC-eligible children you plan to immunize during 2007, by eligibility category.

We have enclosed an information sheet with suggestions to help you develop your 2007 estimates. We suggest that you base your estimates on your vaccine usage for the 12 month period of January 1, 2006 through December 1, 2006. Your reported VFC vaccine usage for that period is summarized on the enclosed report of "Doses Distributed vs. Doses Administered".

The column headed "Acquired-Admin" is our computer projection of VFC vaccine you held in inventory on December 31, 2006. Please carefully review these inventory projections and adjust them as needed if they do not reflect information on your records.

Your VFC Representative can help you develop your 2007 estimates. The enclosed list provides the name and contact number of your representative. Please confirm that your vaccine delivery address, dates and times for delivery are recorded correctly. This information is essential to getting your vaccine orders to you at a location and time your staff can receive them.

**VFC Provider Profile Form-Supplemental (DHS 8499S 5/07)**

On this form, please list all the people at your facility with prescription writing privileges who will administer VFC vaccines. The list requires the license number and National Provider Identifier (previously Medi-Cal or CHDP Number) for each provider. If you have more than 25, please use additional copies of this form to list them.

This form is needed even if there is only one person with prescription-writing privileges at the site. Nurse practitioners and others who operate clinics under licensed physicians should record their information on the forms for the physicians who have signed their Standing Orders.

**Please complete your recertification package and mail to us by *September 6, 2007***, to keep your VFC account active. After September 10, 2007, the completed forms will be required prior to processing any vaccine orders.

Before submitting your forms, make sure your correct six-digit VFC customer number (PIN) is recorded in the space on the top of each of the forms.

**Please mail your recertification paperwork to:**  
**VFC Program**  
**California Department of Health Services**  
**Immunization Branch**  
**850 Marina Bay Parkway**  
**Building P, Second Floor**  
**Richmond, CA 94804**

If you have any questions about the VFC program or completing these forms, please contact your VFC Representative or call 1-877-243-8832 to speak to one of the VFC Customer Service Representatives.

Thank you for your cooperation.

Enclosures:

“Report of Doses Distributed vs. Doses Administered” (specific to each practice)  
Provider Profile-(2 part NCR)  
Provider Enrollment-(2 part NCR)  
Supplemental (2 part NCR)  
Information Sheet on How to Develop Estimates  
List of VFC Field Representatives

# VACCINES FOR CHILDREN (VFC) PROGRAM PROVIDER PROFILE FORM

PIN (6 digit)
COUNTY

**THIS IS NOT A VACCINE ORDER FORM.** However, this form will help the State determine the amount of vaccine it will supply to participants in the VFC Program. The State also may use the information to compare the estimated needs of providers for vaccine with actual vaccine orders submitted.

It is a federal requirement that each enrolled site to which VFC Program vaccines will be delivered must complete and submit this form with a VFC Program Profile-Supplemental Form (DHS 8499S) to the address below at least once a year to receive VFC-supplied vaccine. Each enrolled site also must submit a Provider Profile Form and Profile-Supplemental Form whenever (1) the estimated of eligible children to be served changes; (2) the status of the facility changes (e.g., a private provider becomes an agent of a federally qualified health center, etc.), or the persons with prescription-writing privileges changes. This form may be completed by one provider or the entire practice.

**Please Print or Type.** **Date:** \_\_\_\_\_  
 NAME OF PHYSICIAN'S OFFICE, PRACTICE, CLINIC, ETC. \_\_\_\_\_

IF THIS OFFICE, CLINIC, ETC., IS PART OF A LARGER CORPORATE ENTITY OR DEPARTMENT, THE NAME OF THAT ENTITY IS: **STATE USE ONLY**  
 Parent PIN: \_\_\_\_\_

EMPLOYER IDENTIFICATION NUMBER	MEDICAL LICENSE NUMBER	CHDP PROVIDER: <input type="checkbox"/> No <input type="checkbox"/> Yes	MEDI-CAL PROVIDER: <input type="checkbox"/> No <input type="checkbox"/> Yes	National Provider Identifier (NPI)
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TYPE OF FACILITY (Please Check The One Box That Represents the Bulk of Your Practice)

Public Hospital  Public Health Department  Other Public Sector (Specify) \_\_\_\_\_

Non Profit Community Health Center  Private Practice  Private Hospital  Other Private Sector (Specify) \_\_\_\_\_

PLEASE INDICATE IF ANY OF THE FOLLOWING INFORMATION HAS CHANGED.

Vaccine Delivery Information  Mailing Information  Telephone Number  Fax Number  Email Address  Times and Days for Delivery

Vaccine Delivery Information	Mailing Information <i>(If different from shipping information)</i>
CONTACT PERSON:	CONTACT PERSON:
VACCINE DELIVERY ADDRESS (Number/Street-No P.O. Boxes):	MAILING ADDRESS:
CITY: ZIP:	CITY: ZIP:
TELEPHONE NUMBER: ( )	EMAIL ADDRESS:
FAX NUMBER: ( )	

DAYS AND TIMES FOR DELIVERY (Specify ALL days and times during which you may receive vaccine deliveries)

Tues (Times: \_\_\_\_\_)  Wed (Times: \_\_\_\_\_)  Thurs (Times: \_\_\_\_\_)  Fri (Times: \_\_\_\_\_)

Estimated number of children who will receive immunizations at your practice or clinic for a 12-month period, by category.*	Ages <i>(Note: Do not count a child in more than one category.)</i>			TOTAL
	<1	1-6	7-18	
1. CHDP/Medi-Cal Eligible				
2. Without Private Insurance				
3. American Indian or Alaskan Native				
<b>SUBTOTAL (1+2+3)</b>				
4. Not Eligible for VFC Program Vaccine (Include children with health insurance, Healthy Kids, Healthy Families, and subscribers)				
<b>TOTAL (1+2+3+4)</b>				

\*Choose only one category for each child. If the child meets two or more of the eligibility qualifications, choose the first one that applies.

TYPE OF DATA USED FOR ESTIMATES

Doses Administered Reports  CHDP/Medi-Cal Claim Data  Other (Specify) \_\_\_\_\_

Please send the white copy (original) to this address:  
and retain the yellow copy for your records.

Vaccines for Children (VFC) Program  
 California Department of Health Services  
 Immunization Branch  
 850 Marina Bay Parkway, Building P  
 Richmond, CA 94804  
 Toll-free Telephone: 877-2Get-VFC (877-243-8832)  
 Toll-free Fax: 877-FAXX-VFC (877-329-9832)



# VACCINES FOR CHILDREN (VFC) PROGRAM PROVIDER ENROLLMENT FORM

		PIN (6 digit)	
		COUNTY	
NAME OF PHYSICIAN'S OFFICE, PRACTICE, CLINIC, ETC.		DATE	
ADDRESS (Number and Street)		CITY	ZIP CODE
CONTACT PERSON	NATIONAL PROVIDER IDENTIFIER (NPI)	TELEPHONE ( )	FAX ( )
EMPLOYER IDENTIFICATION NUMBER	MEDICAL LICENSE NUMBER	EMAIL ADDRESS	

To participate in the Vaccines for Children (VFC) Program and receive federally procured vaccine provided to my facility at no cost, I agree to the following conditions, on behalf of myself and all the practitioners, nurses and others associated with this medical office, group practice, managed care organization, community/migrant/rural clinic, health department, or other health delivery facility of which I am the physician-in-chief or equivalent:

- I will screen patients and administer VFC Program-purchased vaccine only to a child who is 18 years of age or younger who qualifies under one or more of the following categories:
  - Is an American Indian or Alaskan Native;
  - Is eligible for California's Child Health and Disability Prevention (CHDP) Program or Medi-Cal Program; or
  - Has no health insurance.

Note: Children with private health insurance and Healthy Family subscribers are not eligible for VFC vaccines.
- I will maintain a record of each VFC-enrolled child's required information on VFC eligibility screening for a period of three (3) years. Release of such records will be bound by the privacy protection of the federal Medicaid law.
- If requested, I will make such records available to the State or the Department of Health and Human Services (DHHS).
- I will permit visits to my facility by authorized representatives of the State or DHHS to review my compliance with VFC Program requirements including vaccine storage and record-keeping.
- I will administer VFC vaccines only to children in eligible age cohorts for each vaccine, as set by the Advisory Committee on Immunization Practices (ACIP) in VFC resolutions.
- I will administer all age-appropriate immunizations to patients in my practice in compliance with the recommended immunization schedule, dosage, and contraindications that are established by the ACIP, unless:
  - In my medical judgment, and in accordance with accepted medical practice, I deem such compliance to be medically inappropriate; or
  - The particular requirement contradicts the law in my State pertaining to religious and other exemptions.
- I will distribute written vaccine information (e.g. Vaccine Information Statements [VISs]) and maintain records in accordance with the National Childhood Vaccine Injury Act.
- I will not impose a charge for the cost of the vaccine.
- I will not impose a charge for the administration of the vaccine that is higher than the maximum fee established by the State. (The current maximum for the State of California is \$17.55 per dose administered.)
- I will not deny administration of a federally procured vaccine to a child because the child's parent or guardian or individual of record is unable to pay the administration fee.
- I will comply with the State's requirements for ordering vaccine as outlined on VFC order forms, etc. (e.g., reporting via the order forms my previous VFC vaccine usage and my current inventory of VFC vaccine, ordering vaccine according to the order frequency category identified for my practice, etc.)
- I will be financially responsible for the replacement cost of any VFC-provided vaccines that I receive for which I cannot account or that spoil or expire because of negligence.
- I agree to store and handle VFC-supplied vaccines in accordance with the manufacturer's specifications and only at the facility stipulated in this agreement. I may be required to purchase a new refrigerator or freezer unit if equipment at my practice is deemed inappropriate for vaccine storage or not able to maintain appropriate temperature.
- I will use the VFC provided Fahrenheit (F°) Temperature Log or Celsius (C°) Temperature Log on all cold storage units that contain vaccines, and retain the "Temp Log" (IMM-682) record each month for a period of thirty six (36) months.
- I understand the State may terminate this agreement at any time for failure to comply with these requirements or without cause.**

Note: I understand that if this agreement is terminated, I must return to the VFC Program all unused (viable and non-viable) VFC vaccine. I also will comply with the VFC Program's procedures for return of the vaccine.

CHIEF PHYSICIAN'S NAME	SIGNATURE	DATE
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To be enrolled in and receive vaccines through the VFC Program (or to receive other federally procured vaccines), you must submit the white copy (original) of this form **with an ORIGINAL signature** to the following address. (Please retain the yellow copy for your records.) **FAXED COPIES OF THIS FORM WILL NOT BE ACCEPTED.**

**Mail original copy to:** VFC Program, State of California, Department of Health Services, Immunization Branch  
850 Marina Bay Parkway, Building P, Richmond, CA 94804



# VACCINES FOR CHILDREN (VFC) PROGRAM PROVIDER PROFILE FORM—SUPPLEMENTAL

PIN (6 digit)	
COUNTY	
DATE	
CITY	ZIP CODE
TELEPHONE (    )	FAX (    )

NAME OF PHYSICIAN'S OFFICE, PRACTICE, CLINIC, ETC.	
ADDRESS (Number and Street)	
CONTACT PERSON	EMAIL ADDRESS

LAST NAME, FIRST, MI	NATIONAL PROVIDER IDENTIFIER (NPI)	MEDICAL LICENSE NUMBER	TITLE (e.g., MD, DO, NP, PA— Provider must have prescription writing privileges)	SPECIALITY (e.g., Peds, Family Med, GP, Other [Specify])
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				
16.				
17.				
18.				
19.				
20.				
21.				
22.				
23.				
24.				
25.				

**Instructions:** You must use this form to list all health care providers at your facility with prescription writing privileges who will administer VFC Program-provided vaccines. (You may use additional copies of this form to list additional providers.) Submit this form with the VFC Provider Profile Form.

**Note:** It is not necessary to include the names of all staff who may administer VFC vaccine, but rather only those who possess a medical license or are authorized to write prescriptions.





# VFC Provider Profile Form

## Suggestions for Developing Estimates

### 1. Determine the “Number” of vaccine doses administered

- Using the enclosed report of “Doses Distributed vs. Doses Administered”, record the number of diphtheria-containing vaccines DTaP, and/or DTaP/HB/IPV-Pediarix (excluding Td and Tdap) that appear under the “DOSES ADMIN” column. Enter the TOTAL number of DTaP, and/or DTaP/HB/IPV-Pediarix administered in the TOTAL column (A).

**Table 1a.** You will use these numbers in steps 4a and 5a.

Doses Administered	DTaP	DTaPHBIPV (Pediar	TOTAL (A)
Example	150	50	200
Your clinic numbers →			

- Record and TOTAL the number of MMR-containing vaccines, MMR and/or MMRV that appear under the “DOSES ADMIN” column. Enter the TOTAL in the TOTAL column (B).

**Table 1b.** You will use these numbers in step 6a.

Doses Administered	MMR	MMRV	TOTAL (B)
Example	50	50	100
Your clinic numbers →			

### 2. Estimate the “Percent” of patients in each of the following categories served by the practice/clinic during January 2006-December 2006.

**Table 2.** You will use this in steps 4b, 5b, and 6b.

ELIGIBILITY CATEGORY ⇒	VFC Eligible	Not VFC Eligible (Include children with private health and Healthy Families Program subscribers. Facilities that are not nonprofit community health centers also should include underinsured children).	TOTAL (EQUAL TO 100%)
Example	60%	40%	100%
Your clinic numbers →			

**Table 3.** You will use this in steps 4a, 5a, and 6a.

VFC ELIGIBILITY CATEGORY ( C )	Medi-Cal/CHDP Eligible	Without Private Insurance	American Indian or Alaskan Native	Underinsured (CHC only)	TOTAL (EQUAL TO 100%)
Example	70%	20%	10%	0%	100%
Your clinic numbers →					

### 3. Enter amounts calculated in steps 4-6 described below, and transfer information to Profile Form.

Estimated number of children who will receive immunizations at your practice or clinic for a 12-month period, by category	Ages			Total
	<1 (Step 4)	1-6 (Step 5)	7-18 (Step 6)	
1. CHDP/Medi-Cal Eligible				
2. Without Private Insurance				
3. American Indian or Alaskan Native				
<b>Nonprofit community health centers only ONLY</b>				
4. Underinsured –health insurance that does NOT pay for vaccines				
Subtotal = (1+2+3+4)				
5. Not Eligible for VFC Program Vaccine				
<b>TOTAL = (1+2+3+4+5)</b>				



# VFC Provider Profile Form

## Suggestions for Developing Estimates

### 4. Determine the Number of Children <1 Year of Age

#### A. VFC Eligible Children

- Multiply the TOTAL (**A**) number of doses of diphtheria-containing vaccines administered (Table 1a), by **0.2**. This will give you the TOTAL number of VFC-eligible children <1 year of age (**B**).

Example: 200 doses (**A**) x **0.2** = 40 VFC-eligible children <1 year of age (**B**).

- Use this number (**B**) and your estimated percents of children served in each VFC-eligibility category entered in the table in 3, to determine the number of VFC-eligible children in each VFC eligibility category (**C**): Multiply TOTAL number of VFC-eligible children <1 year of age (**B**) by each of the estimated percents in Table 3.

Example: If you have 40 VFC-eligible children and approximately 70% of these are Medi-Cal/CHDP eligible, multiply 40 x .70 which equals 28. You would estimate that you have 28 Medi-Cal/CHDP eligible children <1 year of age. Without insurance: 40 X .20= 8. American Indian: 40 X .10=4.

#### B. Non-VFC-Eligible Children (Private Paying Patients)

- Divide the total number of VFC eligible children <1 year of age (**B**) by your estimate of the percentage of the total number of children <1 year of age who are VFC eligible (Table 2).
- Subtract the total number of VFC eligible children from this number.

Example: If you have 40 eligible children <1 year of age and you estimate that approximately 60% of your total <1 population is VFC eligible, you would divide 40 by .60 for a result of 66. You then subtract 40 from 66 to find you have 26 children <1 year of age who are non-VFC-eligible.

### 5. Determine the Number of Children 1-6 Years of Age

#### A. VFC Eligible Children

- Multiply the TOTAL(**A**) number of doses of diphtheria-containing vaccines administered (Table 1a), by **0.4**. This will give you the total number of VFC-eligible children 1-6 years of age (**D**).

Example: 200 doses x **0.4** = 80 VFC-eligible children 1-6 years of age (**D**).

- Use this number (**D**) and your estimated percents of children served in each VFC-eligibility category entered in the table in 3, to determine the number of VFC-eligible children 1-6 years of age in each VFC eligibility category (**C**): Multiply TOTAL number of VFC-eligible children 1-6 years of age (**D**) by each of the estimated percents in Table 3.

Example: If you have 80 VFC-eligible children and approximately 70% of these are Medi-Cal/CHDP eligible, multiply 80 x .70 which equals 56. You would estimate that you have 56 Medi-Cal/CHDP eligible children 1-6 years of age. Without insurance: 80 X .20= 16. American Indian: 80 X .10=8.

#### B. Non-VFC-Eligible Children (Private Paying Patients)

- Divide the total number of VFC eligible children 1-6 years of age (**D**) by your estimate of the percentage of the total number of children 1-6 years of age who are VFC eligible (Table 2).
- Subtract the total number of VFC eligible children from this number.



# VFC Provider Profile Form

## Suggestions for Developing Estimates

Example: If you have 80 eligible children 1-6 years of age and you estimate that approximately 60% of your total <1 population is VFC eligible, you would divide 80 by .60 for a result of 133. You then subtract 80 from 133 to find you have 53 children 1-6 years of age who are non-VFC-eligible.

### 6. Determining the number of VFC Eligibles 7-18 Years of Age

#### A. VFC Eligible Children

- Multiply the TOTAL **(B)** number of doses of MMR-containing vaccines (MMR and /or MMRV) administered (Table 1b) in by **0.50**. This will give you the total number of VFC-eligible children 7-18 years of age **(E)**.

Example: 100 doses x **0.5** = 50 VFC-eligible children 7-18 years of age **(E)**.

- Use this number **(E)** and your estimated percents of children served in each VFC-eligibility category entered in the table in 3, to determine the number of VFC-eligible children 7-18 years of age in each VFC eligibility category **(C)**: Multiply TOTAL number of VFC-eligible children 7-18 years of age **(E)** by each of the estimated percents in Table 3.

Example: If you have 50 VFC-eligible children and approximately 70% of these are Medi-Cal/CHDP eligible, multiply 50 x .70 which equals 35. You would estimate that you have 35 Medi-Cal/CHDP eligible children 7-18 years age. Without insurance: 50 X .20= 10. American Indian: 50 X .10=5.

#### B. Non-VFC-Eligible Children (Private Paying Patients)

- Divide the total number of VFC eligible children 7-18 years of age **(D)** by your estimate of the percentage of the total number of children 7-18 years of age who are VFC eligible (Table 2).
- Subtract the total number of VFC eligible children from this number.

Example: If you have 50 eligible children 7-18 years of age and you estimate that approximately 60% of your total 7-18 population is VFC eligible, you would divide 50 by .60 for a result of 83. You then subtract 50 from 83 to find you have 33 children 7-18 years of age who are non-VFC-eligible.

(last revised 7/07)