

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

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

\*Contact the PHR in your area to obtain PIN

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

Provider Name (M.D., D.O., N.P., 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: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

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) Before administering vaccines obtained through the Texas Vaccines for Children Program (TVFC), 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 at least three years. If I use the Patient Eligibility Screening form as the sole source of documenting ImmTrac consent, I will maintain this record until the child has reached his/her 19<sup>th</sup> birthday. If requested, my office 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) My office 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, 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 (VIS) to the responsible adult, parent, or guardian and maintain records in accordance with the National Childhood Vaccine Injury Act. (Signatures are not required for the Vaccine Information Statements but are recommended.)
- 5) My office will not charge for vaccines supplied by DSHS and administered to a child who is eligible for the TVFC.
- 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 DSHS. 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 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) My office will comply with the State's requirements for ordering vaccine and other requirements as described by DSHS.
- 9) My office or the State may terminate this agreement at any time for personal reasons or failure to comply with these requirements.
- 10) My office will allow DSHS (or its contractors) to conduct on-site visits as required by VFC regulations.

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

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

\*The TVFC Enrollment form must be signed by a licensed Medical Doctor, Doctor of Osteopathy, Nurse Practitioner, Physician Assistant, or a Certified Nurse Midwife.



**TEXAS VACCINES FOR CHILDREN PROGRAM  
PROVIDER PROFILE FOR PIN \_\_\_\_\_**

Is your facility a Federally Qualified Health Center, Migrant Health Clinic, or Rural Health Clinic?  
(circle one) YES NO

Type of Clinic: (✓ check one)

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

**PATIENT PROFILE:**

Please enter the number of children for each of the following categories and by age group who will be vaccinated at your clinic in the next 12 month period.

NUMBER OF CHILDREN IN EACH CATEGORY	< 1 year old	1-6 years	7-18 years	Total
Enrolled in Medicaid.				
Uninsured. (Note: Children enrolled in Health Maintenance Organizations are considered insured)				
American Indians.				
Alaskan Natives.				
Underinsured. (Has health insurance that <b>Does Not</b> pay for vaccines, has a co-pay or deductible the family cannot meet, or has insurance that provides limited wellness or prevention coverage)				
<b>(For Public Health Clinic Use ONLY)</b> Children who do not meet any of the above criteria, but still receive vaccinations at <b>public health clinics</b> .				
Children who receive benefits from the Children's Health Insurance Plan (CHIP).				
Children who are vaccinated in your practice, but are <b>NOT</b> TVFC-eligible.				
<b>TOTAL PATIENTS:</b> (Add columns)				

**TEXAS VACCINES FOR CHILDREN PROGRAM  
PROVIDER LIST**

Please list all individuals within the practice who will be administering TVFC supplied vaccine.

Last Name (list provider who signed Provider Enrollment Form first)	First Name	Middle Initial	Title (M.D., D.O., N.P., P.A., R.N., L.V.N., M.A.)	Texas Provider Identification	Medical License Number	Speciality (Family Medicine, Pediatrics, etc.)



