

Oklahoma Vaccines for Children (VFC) Program 2016 Provider Profile Form

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: ___ / ___ / ___

VFC Provider PIN Number# _____

OSIS # _____

FACILITY INFORMATION

Provider's Name: _____

Facility Name: _____

Vaccine Delivery Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Email: _____

FACILITY TYPE (select facility type)

Private Facilities	Public Facilities	
<input type="checkbox"/> Private Hospital <input type="checkbox"/> Private Practice (solo/group/HMO) <input type="checkbox"/> Private Practice (solo/groups as agent for FOHC/RHC-deputized) <input type="checkbox"/> Community Health Center <input type="checkbox"/> Pharmacy <input type="checkbox"/> Birthing Hospital <input type="checkbox"/> School-Based Clinic <input type="checkbox"/> Teen Health Center <input type="checkbox"/> Adolescent Only Provider <input type="checkbox"/> Other _____	<input type="checkbox"/> Public Health Department Clinic <input type="checkbox"/> Public Health Department Clinic as agent for FOHC/RHC-deputized <input type="checkbox"/> Public Hospital <input type="checkbox"/> FOHC/RHC (Community/Migrant/Rural) <input type="checkbox"/> Community Health Center <input type="checkbox"/> Tribal/Indian Health Services Clinic <input type="checkbox"/> Woman Infants and children <input type="checkbox"/> Other _____	<input type="checkbox"/> STD/HIV <input type="checkbox"/> Family Planning <input type="checkbox"/> Juvenile Detention Center <input type="checkbox"/> Correctional Facility <input type="checkbox"/> Drug Treatment Facility <input type="checkbox"/> Migrant Health Facility <input type="checkbox"/> Refugee Health Facility <input type="checkbox"/> School-Based Clinic <input type="checkbox"/> Teen Health Center <input type="checkbox"/> Adolescent Only

VACCINES OFFERED (select only one box)

- All ACIP Recommended Vaccines
- Offers Select Vaccines (This option is only available for facilities designated as Specialty Providers by the VFC Program)

A "Specialty Provider" is defined as a provider that only serves (1) a defined population due to the practice specialty (e.g. OB/GYN; STD clinic; family planning) or (2) a specific age group within the general population of children ages 0-18. Local health departments and pediatricians are not considered specialty providers. The VFC Program has the authority to designate VFC providers as specialty providers. At the discretion of the VFC Program, enrolled providers such as pharmacies and mass vaccinators may offer only influenza vaccine.

Select Vaccines Offered by Specialty Provider:

- | | | |
|-----------------------------------|---|---------------------------------------|
| <input type="radio"/> DTaP | <input type="radio"/> Meningococcal Conjugate | <input type="radio"/> TD |
| <input type="radio"/> Hepatitis A | <input type="radio"/> MMR | <input type="radio"/> Tdap |
| <input type="radio"/> Hepatitis B | <input type="radio"/> Pneumococcal Conjugate | <input type="radio"/> Varicella |
| <input type="radio"/> HIB | <input type="radio"/> Pneumococcal Polysaccharide | <input type="radio"/> Other, specify: |
| <input type="radio"/> HPV | <input type="radio"/> Polio | |
| <input type="radio"/> Influenza | <input type="radio"/> Rotavirus | |

PROVIDER POPULATION

Provider Population 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 the status at the last immunization visit, regardless of the number of visits made. The following table documents how many children received VFC vaccine, by category, and how many received non-VFC vaccine.*

VFC Vaccine Eligibility Categories	# of children who received VFC Vaccine by Age Category			
	<1 Year	1-6 Years	7-18 Years	Total
Enrolled in Medicaid				
No Health Insurance				
American Indian/Alaska Native				
Underinsured in FQHC/RHC/CHD or deputized facility ¹				
Total VFC:				
Non-VFC Vaccine Eligibility Categories	# of children who received non-VFC Vaccine by Age Category			
	<1 Year	1-6 Years	7-18 Years	Total
Insured (private pay/health insurance covers vaccines)				
Total Non-VFC:				
Total Patients (must equal sum of Total VFC + Total Non-VFC)				

¹Underinsured includes children with health insurance that does not include vaccines or only covers specific vaccine types. Children are only eligible for vaccines that are not covered by insurance.

In addition, to receive VFC vaccine, underinsured children must be vaccinated through a Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC), CHD or under an approved deputized provider. The deputized provider must have a written agreement with an FQHC/RHC and the state/local/territorial immunization program in order to vaccinate these underinsured children.

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

- | | |
|--|---|
| <input type="radio"/> Benchmarking | <input type="radio"/> Doses Administered |
| <input type="radio"/> Medicaid Claims Data | <input type="radio"/> Provider Encounter Data |
| <input type="radio"/> IIS | <input type="radio"/> Billing System |
| <input type="radio"/> Other (must describe): | |

Provider Profile Information

All State-approved public and private health care providers participating in the Vaccines For Children (VFC) Program must complete this form. This document provides shipping information and helps the State determine the amount of vaccine to be supplied through the VFC Program. This form also may be used to compare estimated vaccine needs with actual vaccine supply. The State Health Department must keep this form on file with the *Provider Enrollment Form*.

1. Vaccine Delivery Address: _____
Street (No P.O. Boxes)

City, State

2. Primary Vaccine Coordinator (1): _____
Last First

(Legibly Please)

Title

Back-Up Vaccine Coordinator Name (2): _____
Last First

(Legibly Please)

Title

3. Person completing this form (if different than Primary Vaccine Coordinator): _____
Last First

(Legibly Please)

Title

4. **Please specify actual office hours (please do not use a v or X):**

Mon _____ Tue _____ Wed _____ Thur _____ Fri _____ Sat _____

W E E K L Y O F F I C E H O U R S

5. Days and times vaccine may be **delivered** if **different** than office hours.

Mon _____ Tue _____ Wed _____ Thur _____ Fri _____ Sat _____

O F F I C E D E L I V E R Y H O U R S

6. If the office is closed for lunch then please specify the **exact** time the office is closed. _____